Should I stay or should I go? Factors influencing retention of occupational therapists working in mental health services in New Zealand

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ABSTRACT

Occupational therapists play a central role in working with people with mental health issues through the use of meaningful occupations to enable recovery. In the past three to four decades, there have been numerous discussions, studies and position papers that consider retention and attrition in mental health occupational therapy.

Retention, turnover, and job satisfaction are multifaceted and involve various personal and professional factors that influence a person's decision to stay, leave, or take future positions within mental health or occupational therapy. Through a review of the literature, it is evident that such factors are not mutually exclusive and are, in fact, interwoven.

The purpose of this study is to identify the factors considered by occupational therapists working in mental health in New Zealand when making their decisions to stay/remain or leave their current, past and future positions and why?

An exploratory, quantitative, descriptive, cross sectional survey design was conducted. Two hundred and thirty-four participants responded to the survey, approximately 68 percent of the mental health occupational therapists holding an Annual Practicing Certificate (APC) with the Occupational Therapy Board of New Zealand. It identified that the factors that have an influence on Aotearoa/ New Zealand mental health occupational therapists' decisions about leaving, staying or applying for other positions are multifaceted and include both professional and personal factors.

The survey identified and examined the 'push, pull, attract' concepts and factors relevant to OTs working in mental health in Aotearoa / New Zealand. Some of the key findings were that OTs value the direct client contact, opportunities for professional growth and relationships with peers and team, while lack of respect from the team, justifying OT services and role blurring are considerations for leaving positions. Key issues relate to management factors such as such as recognition and rewards, performance feedback, support from manager, and management style of the team. Stress and burnout for OTs working in mental health is an issue. OTs are wanting autonomy and flexibility with their work with professional development seen as a major benefit. The top attractions for OTs into another position are salary and career promotion.

By developing some retention strategies, particularly at a management level, we can ensure we support OTs to work in mental health throughout their careers. With the current trends showing a rise in demand for mental health services, we can be proactive in ensuring that we maintain, increase and upskill along with promoting OTs working in mental health services in New Zealand to meet the needs of clients by using meaningful occupations to improve health and wellbeing.

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TABLE OF CONTENTS

Abstract iii
Acknowledgements iv
Table of Contents v
List of Figures ix
List of Tables x
List of Abbreviations xi
Chapter One: Introduction 1
Thesis structure 1
History and Context 2
Health 2
Health and Occupational Therapy 3
Funding and Policy 4
The scope of practice of occupational therapists in Aotearoa/New Zealand 4
New ways of working with changing systems 5
Consumer perspective 5
Media and Society 5
Recruitment and retention 6
Job satisfaction and turnover 6
New Zealand mental health retention context 7
Push (Attrition) and Pull (Retention), and Attract (Attraction, Lure or Entice) 7
Personal Connection to the Topic 8
The Rationale for this Study - Why Occupational Therapists need to stay in Mental Health. 9
Chapter 2: Literature Review 10
Introduction 10
Literature methods 10
The structure of literature review 11
What is the Literature saying/ What do we already know about this topic? 11
Multiple and Complex Factors Affecting Retention 12
Why leave a position? 13
Where would I go? 14
Why stay in current position? 14
Anecdotal factors to review 15
Model of staying in, leaving or being attracted from a position. 18
Job satisfaction 19

Summary and key messages of the literature review 20
Limitations of the literature review 21
Gaps in the Literature 21
Rationale for further study 22
Research Questions 23
Chapter 3: Methods 25
Introduction 25
Survey design and development 25
Survey development support 26
Piloting and validity 27
Recruitment and survey procedure 28
Recruitment 28
Inclusion and exclusion criteria 29
Ethics and consultation 29
Informed consent 30
Cultural consultation and considerations 30
Anonymity and confidentiality 31
Sharing and disseminating the results 31
Data collection 31
Analysis 32
Chapter 4: Results 34
Response Rate 34
Participants 35
Geographical location 35
Ethnicities 36
Current Age ranges of OTs working in mental health in New Zealand 37
Gender 38
Summary of Demographics 39
Working life: Work of the participants 39
Year of Qualification 39
Years of work due to OT qualification 39
Length of time working in mental health 40
Number of positions held in mental health 40
Current Position- Duration in current mental health position- Length of time 41
Previous positions- how long in past position- length of time 41
Annual Practising Certificate 41

Summary of working lives of participants 42
Current position in mental health 42
Employers/ Sector employment 42
Client demographics 43
Team/ Setting 44
Job Titles 45
Discipline vs generic position 46
Hours per week participants generally work 46
Pay Range 47
Management 48
Summary of participant's current positions in mental health 48
Roles 48
Senior/ management responsibilities 48
Time split manager/ clinician 49
Split between management and clinical 49
Tasks/ Roles in undertaken in a position 50
Summary of Roles 51
Factors that influence retention 51
Satisfaction 51
Retention and Attrition 53
Relationship between views on current role and job satisfaction 53
Retention/ Pull 59
Current Pull 59
Perks/ Benefits of current position 59
Current Job- Rewards/ positive aspects 60
Staying in a past position- past pull 61
Summary of retention (pull) 62
Attrition/ Push 62
Current position- Leaving or quitting 62
Current position- Stressors and Demands 63
Current position- Turnover intent. 64
Current position- Push in the future 65
Past Position- Leaving or Quitting 66
Summary of attrition from current and past positions 67
Attraction- Lure and Entice 67
Attraction away from current position- Lures and enticements 67

Current Position- Attraction 68
Disagree with factors attraction to current position 73
Summary of attractions of current and past positions 73
Frames of Reference in mental health occupational therapy 74
Occupational Therapy Frames of reference/ models used in practice 74
Practice models, other non-occupational therapy models or frames of reference guide that current practice 75
Chapter 5: Discussion 78
Introduction 78
Retention: The 'Pull' to stay in a current position and past positions. Why stay? 78
Stay in Current position 79
Relationships with team 81
Why did OTs stay in past positions? 82
Attrition: The 'Push' to leave a current position and past positions. Why leave? 83
Attrition from current position. 83
Attrition from past position 85
Attraction/ Enticement: The 'Attraction' away from a current position and past positions. 86
Attraction from an OTs current position. 87
Attraction into this position from a previous OTs position 88
Push and Pull Diagram 88
Strengths and Limitations of the study 91
Further research needed 92
Conclusion 93
References 95
List of Appendicies 105
Appendix A: Sample of research articles included in literature review 106
Appendix B: Methods: Survey development table 107
Appendix C: Master list of survey questions- Retention of OT's in mental health in A/NZ 110
Appendix D: Screenshot example of online Qualtrics survey layout 125
Appendix E: Ethical approval from Otago Polytechnic ethics committee 126
Appendix F: Participant information sheet 127
Appendix G: Email invitation to participate in survey 129
Appendix H: Closing of the survey email 130
Appendix I: Results of survey 131

LIST OF FIGURES

Figure 1: The multiple factors involved in the see-saw of staying or leaving a position 19
Figure 2: Geographical locations of the participants 36
Figure 3: Age range of participants 38
Figure 4: Occupational therapist's years of working in mental health 40
Figure 5: Number of positions held by OT's in mental health 41
Figure 6: Participants employers/ sectors of work 43
Figure 7: Participants areas of practice in mental health services 45
Figure 8: Job titles of participants 46
Figure 9: Types of work of participants discipline specific vs generic work 46
Figure 10: Hours at work per week for participants in mental health services 47
Figure 11: Pay range for participants working in mental health services 48
Figure 12: Allocated hours per week for senior duties 49
Figure 13: Perks and benefits of participants 60
Figure 14: Specific occupational therapy model, frame of reference, frameworks used by participants 75

LIST OF TABLES

Table 1: Description of Participants in Initial Phase of Survey 34
Table 2: Geographical Locations of Participants According to Health Workforce Divisions . 36
Table 3: Ethnic breakdown of the participants according to Statistics New Zealand (2005) recommendations 37
Table 4: Age range of participants 39
Table 5: Demographics of Clients that the Participants work with in Mental Health Services 44
Table 6: Tasks and Roles of Participants Working in Mental Health 50
Table 7: Job Satisfaction Rating of Occupational Therapists Working in Mental Health 52
Table 8: Correlation Matrix between Job Satisfaction and Perception to Current Position (Pearson Correlation r) 54
Table 9: Factors Rated According to View of Current Position 57
Table 10: Top 10 Responses of Most Rewarding/ Positive Aspects of Current Position 60
Table 11: Top 10 Factors that have Kept Participants in their Positions in the Past..... 62
Table 12: Top 10 Factors that Might Contribute to Participants Leaving/ Quitting Their Current Position 63
Table 13: Top 10 Stressors and Demands of Occupational Therapists Current Positions in Mental Health 63
Table 14: Turnover Intent relating to Quitting Position and Looking for New Position. 64
Table 15: Top 10 Factors that Participants Would Consider Leaving their Current Positions in the future 65
Table 16: Top 10 Factors that have Prompted Participants to Leave Positions in the Past..... 66
Table 17: Top 10 Factors in Luring Away from Current Position 68
Table 18: Correlation Matrix between Job Satisfaction and Attraction to Current Position (PULL) (Pearson Correlation r)..... 69
Table 19: Factors about why Participants were Attracted to Current Position Rating and Correlation 71
Table 20: Factors on Why Participants Attracted to Current Position, ordered according to Percentage..... 72
Table 21: Non-Occupational Therapy Specific Models: Practice Models/ Frame of Reference Used to Guide Current Practice 76

LIST OF ABBREVIATIONS

Abbreviation	Explanation
A/NZ	Aotearoa New Zealand
APC	Annual Practicing Certificate
CE	Continuing Education
NZAOT	New Zealand Association of Occupational Therapy
OTBNZ	Occupational Therapy Board of New Zealand
OTNZ-WNA	Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa
OT	Occupational Therapist
PD	Professional Development
WFOT	World Federation of Occupational Therapists

CHAPTER ONE: INTRODUCTION

This study considers why occupational therapists (OT) stay or leave positions in mental health services in New Zealand. Only 15 percent of occupational therapists in New Zealand work in the field of mental health (OTBNZ, 2016). Anecdotally and through reports, we know there are significant unfilled vacancies (Te Pou o Te Whakaaro Nui, 2017). We read about the issues for consumers in mental health services—for example, the recently released report entitled 'Thinking Outside the Box' (Shalev, 2017) provides a review of seclusion and restraint in New Zealand. "In one mental health unit, there was no equipment in the yard and patients were not provided with a ball or other ways to work out in the yard" (Shalev, 2017, p.44). Such observations exemplify the continued demand and need for occupational therapists in mental health services to ensure the use of meaningful occupations to engage consumers in activities and thus improve their health.

It was important to conduct this exploratory research study in New Zealand because of the lack of New Zealand-based research of retention and occupational therapists working in mental health. With only a small percentage of occupational therapists working in mental health in New Zealand, it is important to note the discussions of Brintnell, Haglund, Larsson, and Piergrossi (2005) about importance of research in mental health occupational therapy; they argue, "research influences practice…it is difficult to amass evidence without researchers" (p. 13). A lack of research leads to low visibility and limits the spread of new and exciting developments in the mental health field.

Thesis structure

This thesis consists of 6 chapters. Chapter one, the introduction, presents a brief history of occupational therapy in mental health and of occupational therapy within the context of the New Zealand mental health system. The importance of occupational therapy in mental health and retaining staff for the benefit of consumers, management and occupational therapists themselves is presented. The researcher's personal connection to the topic is also explored. Key terms are investigated, including retention, recruitment, job satisfaction, turnover and the interconnection of these terms. The concepts of 'push', 'pull' and 'attraction' are explained in relation to factors that influence them. The rationale for further investigation into the topic of mental health occupational therapy and retention is also introduced.

Chapter 2 presents a literature review that introduces past research and documents the process and key findings of the topic, which include key findings of literature about retention of

occupational therapists working in mental health. The concepts of push, pull, and attract are further explained, and an adapted model, which has been developed, is presented along with its related research questions. Previous evidence about the factors that have an impact on occupational therapist's decision making is presented, leading to a discussion of the limitations and gaps in the literature. This is followed by the rationale for the current study and then the research questions that underpin this study.

Research methods are examined in chapter three with information on the study's methodology and research process. The development of the survey and how the pilot was conducted is explained. Recruitment of the participants for the online survey are discussed in conjunction with the inclusion and exclusion criteria. Ethical considerations, including informed consent and cultural considerations, are then covered. Data collection and analysis is then explained. Finally, the section concludes with information on the limitations of the study.

The fourth chapter presents and describes the data and findings from the study, working through the demographic data and roles of the OT's. Both descriptive and statistical information about the participants' current, past and future positions in relation to the dynamic concepts of push, pull and attract are presented.

The discussion in chapter 5 highlights the study's results and findings in comparison to relevant previous research. Clustering of key factors that influence retention and attrition are discussed, and the main findings and differences between past research and the current study are highlighted. Strengths and limitations of the study have been considered along with further research recommendations. A conclusion is drawn at the end of the discussion.

History and Context

Health

A person's health is more than the absence of disease (World Health Organisation, 2006). Mental health is defined as "a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges" (US Department of Health and Human Services, 2016, Para. 2). Mental illness is one of the fastest growing disabilities in the world (World Health Organisation, 2012). In New Zealand, at least one in six people have been diagnosed with a mental health condition sometime in their lives, and mental health conditions are the third leading cause (11.1%) of health loss in New Zealand (following cancer and blood disorders) (Mental Health Foundation, 2014).

Health and Occupational Therapy

The link between everyday life and health has been recognized for centuries (Canadian Association of Occupational Therapists, 2008). Health and well-being have an effect on a person's ability to engage in life's activities and occupations (Law, Steinwender, & Leclair, 1998). Health improves when the activities and occupations people undertake give meaning and purpose to their lives (Law, 2002). "People need to participate in purposeful and meaningful occupations for their health and wellbeing" (Wicks, 2006, p. 264). Occupations are the everyday activities with which people occupy their time and provide purpose and meaning to life, and the primary goal of occupational therapy is to enable people to participate in these activities (Meriano & Latella, 2016; Mills & Payne, 2015). The World Health Organisation (WHO) has linked health, activity and participation together through the development of the 'International Classification of Functioning, Disability and Health' (ICF)(WHO, 2001).

The origins of occupational therapy are embedded in mental health through the moral treatment movement of the late 18th century and 19th century (Creek & Lougher, 2008). Moral treatment was based on the therapeutic value of engagement in meaningful activities and humane treatment in safe environments (Gutman, 2011). Occupational therapy is grounded in the ethos that 'man, through the use of his hands as energized by mind and will, can influence the state of his own health' (Reilly, 1962, p. 2). The profession's philosophy is based on working with people in a holistic, person-centred manner to support a client's health, well-being, and participation in life to achieve their goals and desired occupations (Kannenberg, Amini, & Hartmann, 2016).

Therefore, Occupational therapists play a central role in working with people with mental health issues through the use of meaningful occupations to enable recovery (Kannenberg, Amini, & Hartmann, 2010). Activities or occupations may include looking after oneself (self-care), enjoying life (leisure) and contributing to the social and economic fabric of the community (productivity) (Sumsion, Tischler-Draper, & Heinicke, 2011).

The links between health, activity and wellbeing have been widely discussed (Creek, 2007), and this has enhanced the position of the occupational therapy profession's role in the healthcare field. The onus is on occupational therapists to take up the challenge.

Funding and Policy

The Ministry of Health predominantly funds mental health services in Aotearoa/New Zealand (A/NZ) through the public healthcare system. The Ministry of Health develops policies and strategies and determines how funding will be allocated. Policies include the New Zealand Health Strategy (Ministry of Health, 2016) and strategies such as 'Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017' (Ministry of Health, 2012). These policies and strategies prioritise areas of need and priority in mental health services. The Ministry of Health works with and oversees 20 regional District Health Boards throughout New Zealand that implement the strategies in practice for the people of New Zealand. In a recent newspaper interview, Ministry of Health spokesman, Dr John Crawshaw, discussed the increase in mental health funding. Since 2008/09, the 20 DHBs mental health expenditure had increased by over $300 million from $1.1 billion to $1.4 billion. Funding was ring-fenced so the DHB's have discretion about funding allocation and where to increase its mental health services, but it cannot spend less than the previous year (Carville, 2017).

Along with changes in funding and policy development, mental health reform and changes in service provision around the world have been ongoing, with significant developments and challenges to staff and working within these systems. In New Zealand, these changes have had an impact on the roles of occupational therapists, such as discipline versus generic work (Lloyd, McWha, & King, 2003) and caseload numbers. As early as 1999, Lloyd, Konowski, and Frikkie (1999) discussed the challenges and opportunities for occupational therapy in the implementation of new health and mental health policies and plans.

The scope of practice of occupational therapists in Aotearoa/New Zealand

Occupational therapists working in mental health services are held accountable under the Health Practitioners Competency Assurance Act (2003) (HPCAA) (Ministry of Health, 2003). A person working with the title or using the skills in the role of an occupational therapist must register and hold an APC with the Occupational Therapy Board of New Zealand (OTBNZ) - the regulatory body. Occupational therapists must also abide by the Occupational Therapists Code of Ethics (OTBNZ, 2015). Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa (OTNZ-WNZ) is the national association that represents and provides support and advocacy to occupational therapy professionals in Aotearoa New Zealand (OTNZ-WNA, 2017). OTNZ-WNA has also released a position statement for occupational therapists working in mental health and addiction services to provide a scope of practice and key tasks in the role (OTNZ-WNA, 2012).

Although this may not be the view from OT's themselves, a report by the Ministry of Health discusses that there may be a perception within mental health services management that occupational therapists fail to play a key role in a person's recovery and wellness. This perception that OTs are not a part of planning and development/ service delivery is likely due to limited understanding of the roles of occupational therapists by management, providers and other health professionals (Ministry of Health, 2016).

New ways of working with changing systems

In New Zealand, mental health services regularly employ small numbers of OTs in a particular site, which could contribute to attrition issues due to a lack of discipline-specific comradeship (Anonymous, personal communication, May 3, 2017). To help combat the risk of staff leaving the mental health workforce, Health Workforce New Zealand has established an Allied Health, Science and Technical Taskforce and associated work programme to study recruitment and retention among other issues, such as education and training (Ministry of Health, 2016). Occupational therapists, like other allied health workforces, are small in number when compared to doctors and nurses in the health field. Fifteen percent of occupational therapists with an APC in New Zealand work in mental health, compared with forty-seven percent in physical health. (OTBNZ, 2016).

Consumer perspective

Retaining staff not only relates with the concerns of practitioners; retention has an effect on consumers who benefit from continuity of support as part of their mental health recovery process (Anthony, 1993). 'Recovery' from mental illness is a consumer driven process and involves active participation on their part (Te Pou o Te Whakaaro Nui, 2013; Anthony, 1993). It is up to the occupational therapist to work with the client to ensure the necessary services and supports are in place to enable their own recovery and journey (Lloyd, Tse & Bassett, 2004). Thus, retention of staff is also important to consumers.

Media and Society

The way mental illness is portrayed and reported in the media and press is very powerful in educating and informing the public. A number of high-profile mental health issues have been publicised, and I have corresponded with an occupational therapist who discussed how this adds pressure and strain to mental health teams already stretched to their workload capacity (Anonymous, personal communication, February 23, 2017).

The 'Like Minds. Like Mine' campaign (Mental Health Foundation, 2016) is a public awareness programme that aims to increase social inclusion and reduce (end) discrimination

for people with mental illness. The philosophy of such a campaign of inclusion works well within the occupational therapy paradigm and recovery principles to ensure that people with mental health issues are involved in their chosen occupations.

Recently, a crowd- funding story based inquiry into New Zealand mental health services published a document 'The People's Mental Health Review Report'. Numerous New Zealand people if influence (e.g. Mike King) made comments to the media on the state of New Zealand mental health, further pushing New Zealand mental health services into the public domain. Staff and clients were able to submit their stories online, and key themes were developed. The report identified that a 'lack of resources, and the resulting overwork and stress is also having a negative impact on the mental and physical health and wellbeing of people working in the mental health system' (Elliott, 2017, p. 17). Therefore, the influence in mental health services is not just from government, DHB's, the clients and staff, but also the public as awareness begins to grow of the situation of mental health services in New Zealand.

Recruitment and retention

Recruitment (getting a new staff member) and retention (keeping them) are two different but related concepts (Boushey & Glynn, 2012). Following recruitment, an employee (in this case, an OT) requires orientation to ensure familiarity with their position, consumer input, policies, culture, and context. This is costly exercise both in terms of finances and the time involved for both the new employee and those providing the orientation; however, such orientation and training is needed to retain staff (Heathfield, 2012). From a management perspective, retention relates to keeping staff in their workforce. The time, energy, brainpower, and resources involved in recruiting new staff can be better spent on other tasks, such as the advocacy and care of clients. The cost of employees leaving (attrition) and recruiting new staff does not end with position advertising, but also time, energy, resources, consumers, and coverage. Replacing an employee (recruiting and retaining through orientation and training) costs approximately 20 percent of an annual salary (Boushey & Glynn, 2012).

Job satisfaction and turnover

When a number of events or factors come about/eventuate, this can have a flow on effect to the staff and cause a domino effect—one element influences another, leading to another, and so on. Turnover, the loss of an employee from a team, has two consequences on an organisation, the cost exacted upon the organisation, and the impact on the staff who remain (Freda, 1992). Job satisfaction "represents an affection or attitudinal reaction to the job" (Spector, 1985, p. 694), so it could be assumed that people stay if they are satisfied in their

position or leave a position that is causing dissatisfaction. In a study involving nurses, lower levels of job satisfaction were related to high turnover (Murray, 2002), and others have found job satisfaction influences factors pertaining to intentions of turnover (Nagy, 2002). Job dissatisfaction, according to Glisson and Durick (1998) and Jastyte (2004) leads to staff turnover. When a staff person leaves, the remaining staff often pick up the extra work, thereby decreasing efficiency and quality of care, while the new staff person is recruited and orientated.

Relationship building is an integral part of working within a team. However, it is difficult to block out time for each team member when staff are at capacity and pushed to their limits due to lack of staffing. Furthermore, a person's job satisfaction is based on a subjective viewpoint, and from anecdotal evidence, those who are overworked are often less satisfied with their work. In a human resources management based study (Kotze & Roodt, 2005) located in South Africa that considered management and specialist staff, a review of past research showed strong correlations and some causal relationships between job satisfaction, employee commitment, and retention. In this thesis, the assumption that job satisfaction is a good proxy for retention is continued.

New Zealand mental health retention context

A 2014 survey of Vote Health funded services in New Zealand for adult mental health and addiction occupational therapist roles reported that occupational therapy positions in DHB's and NGO's had a 9 percent and 5 percent vacancy rate respectively (Te Pou o Te Whakaaro Nui, 2015). This percentage was higher than the average vacancy level across other disciplines surveyed in the DHB and NGO mental health and addictions workforce (5% and 4%). This higher percentage of vacancies is concerning because vacancies lead to positions not being filled and the erosion of the OT identity and role in service (Peck & Norman, 1999). Service demands are ongoing and, in most cases, increase with societal pressure and the increasing spotlight on mental health services in New Zealand (Ministry of Health, 2007).

Push (Attrition) and Pull (Retention), and Attract (Attraction, Lure or Entice)

When considering retention of mental health occupational therapists, several factors influence a person's position. Three concepts describe the dynamics of leaving, staying or being attracted to another position. Positive factors help to keep a person in a position (pull them into it) which links to retention (retaining of staff) whereas, negative factors push a person away or out of the position, leading to attrition and turnover. The attract concept involves those factors that entice or lure people into other positions. They often include factors that are

seen as better or offer what the therapist wants more of. These attraction factors are not necessarily factors related to push factors.

Personal Connection to the Topic

After graduating as an occupational therapist, I worked in mental health services in New Zealand and held a number of positions. Then I decided that I had just had enough. There were numerous reasons that culminated in my decision to leave mental health and New Zealand. I enjoyed aspects of the positions, and these aspects kept me working in mental health. These factors were related to the position and were a mixture of professional factors and personal factors. Professional factors included the system and workplace, pay, flexibility, professional development opportunities and comradeship with colleagues. There were also factors not part of the position or system; these were outside of work, but part of life—personal factors such as the location of the workplace from home, family commitments, the commute to work and urge to travel. Upon initial investigation, it was found that these terms of personal and professional factors were also used by Mills and Millsteed (2002) in their 'Model of Retention Equilibrium'.

Looking back, there were aspects I did not enjoy, but I stayed, and there were also factors that I viewed as the final straw about my decision to leave.

I then moved into management and saw staff coming and going. Reasons for turnover varied but were enough to warrant further thought and analysis. I wondered, why? What was it about the job? Was it their life inside and outside of work that made them decide when to stay and when to leave? What were those factors? Through exit interviews and informal discussions, I discovered that many of the factors were analogous to my earlier experience.

So, what could I do? I wanted my staff to stay, (partly for the consumer and their continuity of care), and move into senior positions and management, mentor others, use their experience and pass their wealth of knowledge on to other OTs. Consumers want to become familiar with those who support them in their journey and not be repeatedly asked the same questions by new staff. From my management perspective, staff retention reduced the amount of time and energy given to recruiting, training and up-skilling staff. There were factors that I had control over as manager and supervisor (professional factors), while other factors (personal) I had no control over (e.g. as occupational therapy is a predominately female profession, many take time off to have children).

The Rationale for this Study - Why OT's need to stay in Mental Health.

The purpose of this study is to identify the factors considered by occupational therapists working in mental health in New Zealand when making their decisions to stay or leave their current, past and future positions and why?

Occupational therapists have skills that make them good candidates for team leaders and progression within mental health services. By investigating the factors identified in a literature review and studies, clinicians and management can identify/ determine what occupational therapists require to stay and be promoted within service.

For clinicians, possessing greater knowledge of retention issues can provide some personal sense making and occupational therapists may be empowered to know that their issues are shared by other therapists. It may raise staff awareness of issues relating to retention and attrition, so that occupational therapists can be aware of the factors and challenges before escalation. When discussing the issues of why staff are leaving when I was a manager related to OT's not being understood by other health professionals. The importance of professional identity is highlighted in this issue- being able to articulate what OT's do and why. A generic way of working or case management was also highlighted while I was a manager as an issue. Role blurring and a lack of professional identity became stressful particularly for OT's who did not have a strong sense of occupation. Possessing professional resilience through the use of an occupational perspective and justifying practice from an occupational perspective and theory reduces role blurring and challenges to professional identity (Ashby, Ryan, Gray, & James, 2013).

To ensure sustainability in practice, OTs need to ensure they are mindful of the need for professional self-care to reduce stressors and changes whilst maintaining professional values (McGee, 2006). Professional identity for all occupational therapists is of high importance.

From an organizational perspective, retaining staff is more cost efficient, and keeping staff who are trained and "oriented to the organization and service is preferable than having new employees" (Scanlan, Still, Stewart, & Croaker, 2010 p. 108). When factors involved with retention are identified, management can look at their staff and the factors that the management have control over and provide extra supports, channel financial energy or review the service provision of that particular area.

Therefore the purpose of this study is to identify the factors considered by occupational therapists working in mental health in New Zealand when making their decisions to stay/remain or leave their current, past and future positions and why?

CHAPTER 2: LITERATURE REVIEW

Introduction

This literature review discusses key concepts, relevant research, and insights into worldwide phenomena in the area of retention of OTs working in mental health. Over the past three decades, numerous discussions, studies and position papers have considered aspects of retention and attrition in mental health occupational therapy which will be considered in this literature review. This exploration of literature looking at retention of occupational therapists in mental health enables the consideration of relevant research, which informs the study's research questions, design, and the instrument itself.

Literature methods

Background literature and past surveys were identified through the online electronic databases 'ProQuest Nursing and Allied Health Source', 'Cumulative Index of Nursing and Allied Health Literature' (CINAHL Complete) and 'EBSCO Host'. Key search terms included 'occupational therapy', 'mental health', 'job satisfaction', 'retention', 'case management/ generic', 'attrition'. Predominately, articles included in the literature review mentioned retention, mental health and occupational therapy in the title, keywords, or abstract. At times, as an alternative to occupational therapy, allied health and nursing were also used for references to health, context, and terms.

Initially, studies published before 2000 were excluded based on the assumption that this would ensure a focus on current issues related to changes in mental health service delivery, contemporary practice, legislation and the present economic climate. However, upon further review of studies published in the 1990s, similar factors regarding retention and the multi-faceted approach were identified. As a result, 1990s background and research was included if relevant to the 2000s studies for replication and historical context.

Other exclusions included studies that mainly addressed recruitment with minimal information pertaining to retention. Retention issues are often 'assumed' from or bundled with recruitment. Initially, studies not related to mental health occupational therapists were excluded, but during a background literature search, some retention study results not explicitly pertaining to mental health occupational therapists matched and added depth and evidence to the issues also identified in the mental health surveys reviewed. For this reason, the literature search was widened to include retention and occupational therapy.

Although occupational therapists are allied health professionals, research relating to allied health was initially excluded because occupational therapy is a unique profession (Mattingly & Fleming, 1994) with its own needs and, as with all allied health professional groups, have a different framework and point of view.

Challenges with professional identity have been linked to generic and case worker roles (Bassett & Lloyd, 2001). There is only a small number of occupational therapists in New Zealand compared to other allied health; for example, there are over 6000 social workers in New Zealand and 52,729 nurses with APC (Ministry of Health, 2015) compared to 2294 OTs. Therefore, only specific occupational therapy research was used to develop and design a survey tool for data collection in order to provide insight into occupational therapists' (unique) reasons for staying in a job.

Additional background reading included consideration of a historical perspective through the discussions and recommendations of other research, as well as the older literature cited or referenced in reviewed articles. The research reviewed and discussed is mostly based on mental health and, as opposed to general occupational therapy, was used due to the context of the mental health services environment and the lack of numbers of OT's in mental health compared to other practice areas.

The structure of literature review

This review of the literature will discuss current research on retention and why retention and recruitment must be separated. The review then goes on to examine the multiple and complex factors studied relating to retention and the antecedents to retention. The concepts of push, pull, and attraction, are analysed together with the revision of an adopted model. Job satisfaction and its relation to retention will be considered. Gaps are described in the literature, and the justification and rationale for a further study is provided, followed by the current study's research questions.

What is the Literature saying/ What do we already know about this topic?

What follows is a summary of the literature reviewed and a justification for why this researcher decided to complete an in-depth study of New Zealand occupational therapists working in mental health.

Research has been conducted in the USA (Bailey, 1990a; 1990b; Freda, 1992), Australia (for example Mills & Millsteed, 2002; Moore, Cruickshank, & Haas, 2006) and Great Britain (e.g. Greensmith & Blumfield, 1989) on the subject of retention of occupational therapists in differing practice areas and mental health occupational therapy specifically (Ceramidas, de

Zita, Eklund, & Kirsh, 2009; Australia- Hayes, et al., 2008; Scanlan, Meredith, & Poulsen, 2013; Scanlan, et al., 2010; Scanlan & Still, 2013; UK: Richards, 1998). Members of the World Federation of Occupational Therapists (WFOT) identified mental health OT numbers as an issue in a global research project (Brintnell et al., 2005). While no A/NZ literature illustrating declining numbers of mental health occupational therapists exists, the Ministry of Health's (2005) document 'Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan' aims to improve opportunities to attract and retain staff, implying there is a retention issue. In addition, in 2016 the Ministry of Health established an Allied Health, Science, and Technical Taskforce that specifically identified recruitment and retention as a task to review. Mental health occupational therapy has been included in initiatives such as 'Skills Matter' (Te Pou o Te Whakaaro Nui, 2012) funding and the allied health post graduate course at Auckland University of Technology (AUT), demonstrating the applicability of the initiative to the occupational therapy workforce and suggesting that retention of occupational therapy mental health staff is relevant to A/NZ.

From a human resources perspective, retention is multi-faceted and involves a multitude of complex personal and professional factors that influence a person's decision to stay, leave or taking another position (Rothwell, Prescott, & Taylor, 2008). Thus, this concept applies not only to mental health, but to the wider occupational therapy discipline.

The literature on retention of occupational therapists is, in general, linked with recruitment (which can sometimes dominate). As early as 1986, Canadian occupational therapists, Polatajko and Quintyn (1986) identified a number of personal and employment related factors that influenced retention among rural occupational therapists. They identified different factors distinguished recruitment and retention. Rugg (1999) reinforced this finding. As previously discussed, due to this distinction between recruitment and retention, the decision was made to focus this study on retention, because although staff can be recruited into a position, the concern is ensuring that staff stay that position. This literature review, therefore, considers retention research involving the multiple factors that occupational therapists consider when deciding whether to stay or go that consequently influence their decision making.

Multiple and Complex Factors Affecting Retention

Factors influencing and affecting retention will now be discussed in relation to occupational therapists and their past, present and future positions and the dynamics of staying in a current position (pull), leaving (push) and attracting to (enticing or luring) positions. For the purpose of this literature review, Appendix A highlights several sample key pieces of literature

reviewed and analysed within the literature search parameters that were used in the literature review and considered in subsequent thinking about the survey.

Why leave a position?

Scanlan and colleagues (2010) and Hayes and colleagues (2008) considered the factors associated with leaving a position. These include wanting a different type of work, wanting to work closer to home (lifestyle), high workload or caseload, feelings of boredom in the position, and a 'mismatch' between home and work commitments. Constraints on a position that influenced whether individuals leave included high workload, how a person's day is structured and the (lack of) work organization, the social and emotional environment, and lack of resources (Ceramidas et al., 2009; Hayes et al., 2008; Scanlan et al., 2010). Also discussed were limited career development and leaving for a career development opportunity (Brintnell et al., 2005; Hayes et al., 2008; Scanlan et al., 2010). Other factors identified include a lack of support and supervision, decreased opportunities to use occupational therapy skills (Scanlan et al., 2010), lack of respect from other health professionals (Scanlan & Still, 2013). An occupational therapist's 'fit' or role within the team was also identified as an issue (Ceramidas et al., 2009). Scanlan and Still (2013) also noted the most common reason for wanting to leave was issues with management (team management and bureaucracy), and participants who did identified issues with management also had a lower job satisfaction score and a higher turnover intent. Also in relation to management and the team, there was a moderate correlation between satisfaction and feedback, rewards and social support. There was also a moderate correlation between a dependent variable of job dissatisfaction (and exhaustion) compared to feedback and rewards (or lack thereof) (Scanlan & Still, 2013).

None of the mental health occupational therapy literature above considered occupational therapists who had already left mental health as a practice area; however, Bailey (1990a) did examine OTs that had previously left positions from all practice areas. These factors included caseload size, paperwork, and the location of the position, most of which had also been highlighted by Scanlan et al. (2013).

Scanlan et al. (2010) and Hayes et al. (2008) reported on factors occupational therapists identified as important when choosing to leave a position. Interestingly, lifestyle reasons (location), work issues, higher income and desire for a different practice area were the top four factors given for wanting to leave current positions. Reasons given for leaving past positions were similar; however, therapists also reported dysfunctional teams and lack of career development opportunities as reasons for leaving past positions. Regarding the desire to leave (but have not left yet), occupational therapists identified their reasons as boredom,

wanting to move into (more) senior roles, and needing career progression (Hayes, et al., 2008; Scanlan et al., 2010).

Where would I go?

World Federation of Occupational Therapy (WFOT) research has shown occupational therapists believe there is a future for occupational therapists in mental health (Ceramidas et al., 2008). However, when students were surveyed about their preferred area of practice, only 19.8 percent of students chose mental health (Ceramidas et al., 2008), with the largest preferences for paediatrics and adults physical health fields. Numerous studies, including an Australian study (Rodgers, et al., 2009), discussed that a placement in a mental health setting for fieldwork during training impacted students' perceptions of mental health and their decision to work in mental health, often for the better. Hayes et al. (2008) reported that studies have shown once an occupational therapist is working in mental health, they are more likely to stay, but once they leave, they often fail to return to this practice area. A transition from mental health occupational therapy from another area of practice is more probable (Hayes et al., 2008). The literature indicates the benefits of recruiting occupational therapists into mental health practice at the beginning of their careers (Hayes et al., 2008), when initial supports can be put in place and retaining staff can be increased. Employers should consider this a retention strategy.

Lloyd et al. (2002) in research about the future of occupational therapy identified potential critical issues for mental health occupational therapists. These included recognition of occupational therapists' core skills from other occupational therapists, concern about and support for generic work roles in the future, and retention issues described as burnout, high workloads, and career structures. These findings concur with current issues found in Australian research by Scanlan et al. (2010) and Hayes et al. (2008).

Why stay in current position?

A number of factors encouraging occupational therapists to stay in their jobs were identified. These included the nature of the work, a supportive team environment and opportunities to use occupational therapy skills and knowledge (Hayes et al., 2008; Lloyd, King, & Bassett, 2002; Scanlan et al., 2010; Scanlan & Still, 2013). In addition, an interest in working in mental health was also cited as an influential factor (Hayes et al., 2008; Scanlan et al., 2010). Throughout the review of research, there were factors considered for staying in a position, some of which we discussed with OT's and the literature review will now look at these key factors.

Anecdotal factors to review

During the initial literature search and review, it became apparently there was a wide variety of factors being researched as separate factors and as collective factors. Informal discussions with colleagues in mental health services in New Zealand were conducted to gauge their thoughts. During these informal discussions, the following four factors- professional development, supervision, resources, and discipline-specific vs. generic work role, were identified as having significant 'pull' or 'push' influences on whether occupational therapists stay or leave positions. These factors were professional development, supervision, resources for assessment and intervention, generic vs. discipline specific roles will now be discussed.

Professional development

Professional development has an impact on recruitment and retention (Craik & Austin, 2000; Hayes et al., 2008; Lloyd et al., 2002). In conjunction with other factors, it was considered by occupational therapists and influenced decisions about staying or leaving positions, but it cannot be considered a sole influence (Hunter & Nicol, 2002).

In both studies conducted by both Hayes et al. (2008) and Scanlan et al. (2010), respondents were overall, satisfied with the professional development opportunities provided, however, time constraints and availability of appropriate training were issues.

Supervision

Supervision as a factor in the retention of occupational therapists has also been explored in previous research. Supervision needs differ (with whom, how often, the format of supervision session) depending on the occupational therapists' work experience. Supervision topics include clinical issues, support, and team dynamics. Senior therapists also focused on management issues (Hayes et al., 2008). Occupational therapists unsatisfied with supervision indicated this was due to limitations in accessing supervision (Scanlan et al., 2010). Hayes et al. (2008) identified that, overall, occupational therapists were satisfied with professional supervision unless it was less than monthly, irregular or if their preference was for a different supervisor. These findings suggest that retention of senior occupational therapists is imperative in ensuring quality supervision opportunities for junior staff (Craik, Austin, & Schell, 1999; Bassett & Lloyd, 2001)

Resources to undertake assessments and interventions

Ceramidas, de Zita, Eklund, and Kirsh, (2009) and Brintnell et al. (2005) reported that obtaining appropriate resources (such as materials) that facilitate engagement in occupation was necessary for therapists. Ceramides et al. (2009) described that over half of occupational

therapists across 6 of 7 countries surveyed (Argentina, Canada, South Africa, USA, Venezuela and Australia) reported inadequate physical resources for delivery of services to the desired professional standard. New Zealand was not included in this part of the survey. Physical resources are vital to quality service delivery, patient outcomes, workplace satisfaction and workforce retention (Brintnell et al., 2005). Some occupational therapists contribute financially to programs to ensure that the professional role and occupation as a therapeutic medium are upheld (Brintnell et al., 2005). It was reported the lack of resources compromised client health and safety (Ceramidas et al., 2009). Lloyd and colleagues' (2002) research about future occupational therapy in mental health identified the need to examine inadequate funding for resources.

Generic and discipline specific roles

A debate has persisted about the use of case management/ generic roles (interchangeable terms) and discipline-specific roles for occupational therapists. With changes to mental health services, the profession has shifted from working in discipline-specific roles to generic roles, particularly in community mental health services. This change began with the deinstitutionalisation process in the 1970's-1980's. The integrated delivery of services ensures an emphasis on clients' needs and has been driven by the demand to improve service user care and increase quality and effectiveness of service delivery (Lloyd, King, & McKenna, 2004). Bassett and Lloyd, (2001) and Lloyd et al. (2002) discuss the debate that services can be delivered by any skilled member of a team. As a result occupational therapists now work in more caseworker or generic role positions, as described earlier in chapter one.

Generic work has had an impact on the roles and tasks of occupational therapists in mental health (Lloyd et al., 2004). Occupational therapists, as case managers/ working in a generic nature, complete the roles of other health professionals, such as medication management, organizing benefits and money, and overseeing all aspects of a person's care. Although some OTs consider that these tasks to fall outside the scope of practice of occupational therapists working from an occupational perspective, the New Zealand Association of Occupational Therapists (NZAOT), (now OTNZ-WNA) has developed a position statement that outlines the scope of practice in the '2012 Mental Health and Addictions Position Statement.' The statement establishes that occupational therapists working in mental health often practice case management, thus demonstrating that it is a legitimate, endorsed role for occupational therapists.

However, concerns that generic work causes a loss of professional identity and role blurring have been voiced (Bassett & King, 2001). Regarding a generic role, the need for a strong professional identity arises for OT's as often they work autonomously and regularly using tacit knowledge in their practice (Mattingly & Fleming, 1994). As a result, they may sometimes be unable to articulate why they do what they have instinctively acted in a certain way. Being unable to articulate the role of an occupational therapist to other professions and what OTs can 'do' adds to the lack of knowledge about occupational therapy exhibited by other health professionals. Role blurring and role confusion are common, particularly in community mental health settings or sole positions. When an OT has not been working in a previous position or with other mental health occupational therapists who act as role models and mentors, the role/function and using occupation as a core construct of working may become blurred and what their actual role is as an OT (Anonymous, personal communication, May 1, 2017). Lloyd et al. (2003), in their New Zealand study, recommended that OTs work to enhance professional confidence by identifying core skills and reviewing the definition of occupational therapy.

The debate over generic versus specialist roles for mental health occupational therapists is ongoing (Cook, 2003; Lloyd et al., 2004; Hayes et al., 2008; Ceramides, 2010, Heasman & Morley, 2012) and has yet to address specifically how factors such as the nature and tasks involved in the role affects retention of occupational therapists.

In a survey of mental health occupational therapists in Australia, Lloyd, et al. (2002) identified that new models of practice have begun utilising both generic and discipline-specific skills from staff within a team. Of note, people were concerned with the generic nature of work (moving away from using their occupational therapy skills) and the need for discipline-specific occupational therapy skills to be utilised (Ceramidas, 2010). Participants in the Lloyd et al. (2002) study were asked about their concerns for the future of occupational therapy. Over 27 percent identified the use of core skills and being recognised by multi-disciplinary team as having unique skills was an issue with role blurring when working as a case manager. Lloyd et al. (2004) also note there are new, expanding skills, expertise and capabilities needed to function in the role of case manager concerning responsibilities, relationships, and models of care. They note that although occupational therapists are taking on generic roles and would prefer to continue completing generic duties, the increase in workload adds time pressure to occupational therapists who also need to undertake discipline specific tasks.

Further training and education may be needed to address workload management and the management of role blurring, with all mental health professions undertaking a range of duties traditionally discipline specific to other professions (Lloyd et al., 2002). Occupational therapists may need occupational therapy discipline specific training that is not met by generic professional development (Hayes et al., 2008).

From the studies, it is difficult to judge whether working in a generic or discipline specific manner has a substantial impact on retention, although, according to Scanlan et al. (2010), there was no difference in satisfaction between Australian occupational therapists in discipline specific positions and occupational therapists in more generic positions. The same authors report that no one specific/ particular task, either in a generic or discipline specific role, pushed or pulled occupational therapists to leave or influenced their retention in a position, so although generic vs. case management has caused debate (Ceramidas, 2010), we need to research the links between work roles and factors further.

Model of staying in, leaving or being attracted from a position.

While most articles only reported and discussed the findings of the research, one mental health research group developed a conceptual model. Scanlan and his colleagues (2010) developed a "push and pull" conceptualization of recruitment, retention and turnover that included the concepts of intrinsic and extrinsic push and pull. The model is based on the themes derived from the analysis of responses in their survey to illustrate the multiple factors that affect retention and turnover. The push concept refers to factors associated with the past and current position that will or have encouraged people to leave, while the pull concept refers to those factors that encourage individuals to stay. The 'Push and Pull' model builds on the concepts of Mills and Millsteed's (2002) 'Retention Equilibrium' model. Scanlan et al. (2010) describe the push and pull concepts as specific features of employment that may support or damage staff tenure, and the diagram outlines the balance of these items and factors. Scanlan et al. (2010) also include the concepts of intrinsic and extrinsic psychology terms (Weitin, 2016) in their model.

Upon reviewing the literature, this researcher developed an adaption of the 'Push and Pull' conceptualisation of retention and turnover (Scanlan et al., 2010) and 'Retention Equilibrium' model (Mills & Millsteed, 2002). The adaptation is shown in Figure (Fig.) 1. This adaptation varies from Scanlan et al. (2010) model because it moves away from intrinsic and extrinsic factors (psychological theory) and simplifies the push and pull and attraction concepts themselves and the dynamics that occur. It was decided to investigate the factors of what are considered the core concepts of the model (push, pull, attraction) but not the professional and

personal factors, nor intrinsic or extrinsic concepts. It also integrates the factors that contribute to the push, pull and attraction into a weighting for the dynamic of seesaw balance. This diagram formed the basis for the development of the research questions.

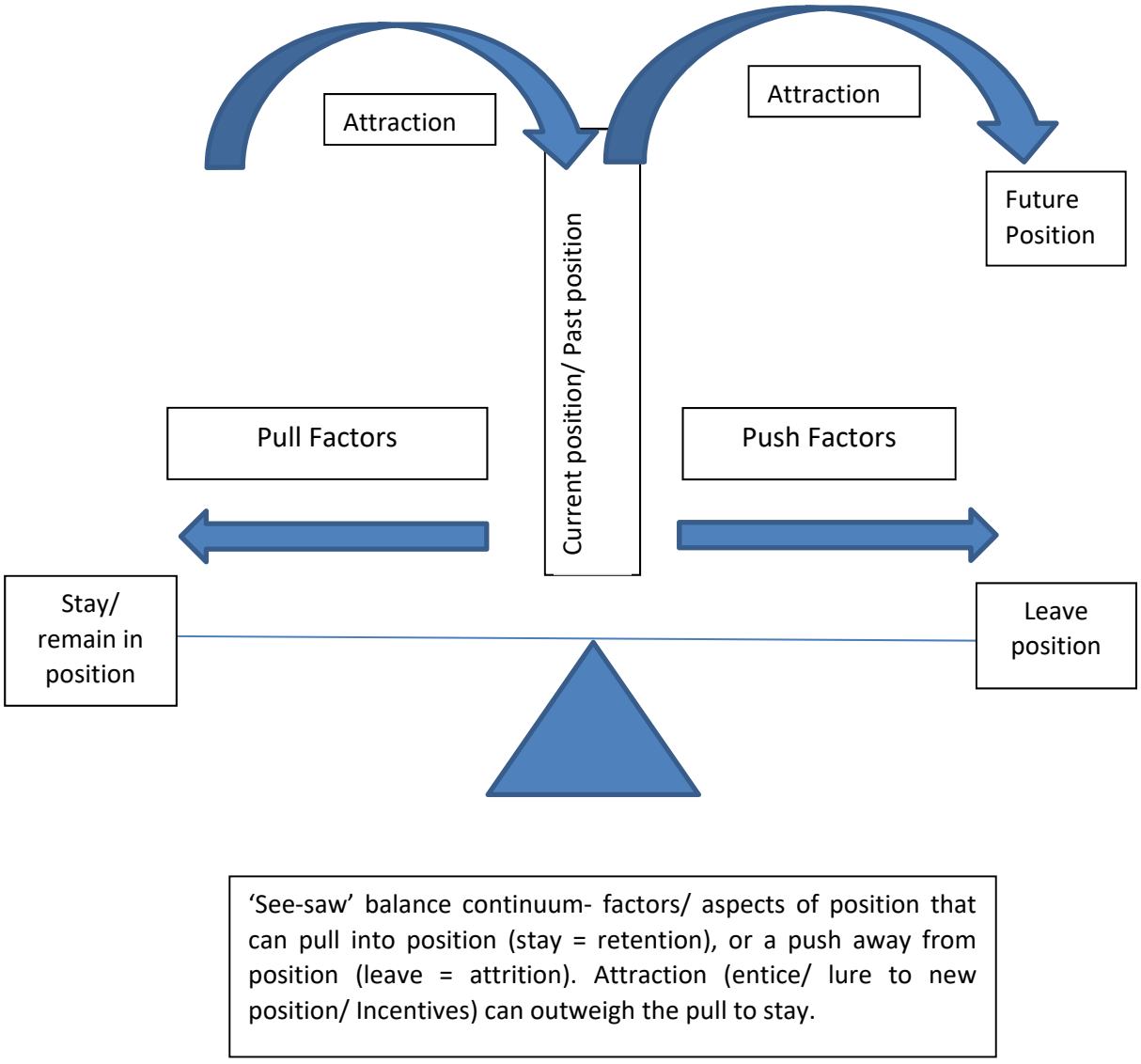

Figure 1: The multiple factors involved in the see-saw of staying or leaving a position

Job satisfaction

According to Freda (1992), an occupational therapist from the USA, job dissatisfaction can be defined as "a state of discontent or displeasure regarding a current position" (p. 241) and can contribute to absenteeism from a position, performance issues and turnover, the last of which is of interest to this study because it pertains to retention. For this reason, in this thesis, job satisfaction will be used as a proxy for retention.

Occupational therapy literature indicated a hypothesized relationship between job satisfaction and retention of occupational therapists (Eklund & Hallberg, 2000; Moore, Cruickshank, &

Haas, 2006). Job satisfaction can be defined as the degree of positive feeling or affect toward the position, the overall job and aspects of it (Panchasharam & Jahrami, 2010; Weisman, Alexander, & Chase, 1981), and the extent to which a person likes their work (Panchasharam & Jahrami, 2010). Moore et al. (2006) found that the importance of autonomy, job diversity (roles and variety within a caseload), and a sense of achievement when working with clients contributed to job satisfaction for all practice areas of occupational therapists. Some of these results concur with a study of Swedish mental health occupational therapists (Eklund & Hallberg, 2000), wherein respondents reported the highest satisfaction when they found their job stimulating. Eklund and Hallberg (2000) also identified the importance of good communication and cooperation among team members as one contributor to increased job satisfaction.

One factor leading to job dissatisfaction in general occupational therapy literature was a misunderstanding of the profession and role by other health professionals and clients. Occupational therapists found their role difficult to define and explain and reported that other practitioners and managers had minimal respect and may not take their opinion into account or know what occupational therapists were able to do with clients (Moore et al., 2006). Scanlan et al. (2010) also identified lack of respect from other health professionals and occupational therapists from practice areas other than mental health as an issue; however, respondents felt that managers did respect and appreciate their work.

Stress and burnout also contribute to job dissatisfaction and affect job performance, self-esteem, absenteeism, and quality of care (Bassett & Lloyd, 2001; Brollier, Beder, Cyranowski, & Velletri, 1986). Stress is caused by factors related to the job, organizational structures and career development (Bassett & Lloyd, 2001; Lloyd et al., 2003).

Stress, burnout and compromised job satisfaction influence retention and contribute to the previously described push and pull concepts (Scanlan et al., 2010)

Those considering changing jobs reported higher stress levels (Lloyd et al., 2003); however, education and further training (professional development and professional growth) are important, may decrease stress levels.

Summary and key messages of the literature review

The literature review has shown that retention is influenced by a multitude of complex factors that impact a person's decision to stay, leave or seek a new position.

A number of studies have focused on one factor and attempted to link it to retention, but as identified earlier in the review, retention is made up of many factors, and the factors that

make a job satisfying or unsatisfying vary (Panchasharam & Jahrami, 2010). As illustrated in the multiple factors section, retention is based on a range of factors that make up the dynamics of the push-pull- attraction concepts as discussed by Scanlan et al. (2010).

Limitations of the literature review

The reviewed research came from a range of locations. The studies by Hayes et al. (2008), Scanlan et al. (2010), Scanlan, and Still (2013) were all conducted in metropolitan mental health services with only current employees. This lack of diversity makes the findings hard to generalise to other settings because of their context (Australian healthcare system) and sample size. However, these studies can provide a basis for and information necessary to assist researchers in investigating occupational therapists working in the mental health field by giving an overview of the factors that the OTs in their studies identified. Readers (for example, OTs) might read this research, agree or disagree with the findings, and examine their own factors influencing their decisions and work. Additionally, Scanlan et al. (2010) acknowledge that their survey was conducted for human resources purposes rather than for the profession's learning. The results were similar across the two surveys, so this has, in fact, added to the awareness of what factors affect occupational therapists in their practice. Because the Scanlan and Still (2013) survey leads on from the work of Scanlan et al. (2010) survey along with the 2010 survey being based on the Hayes et al. (2008) survey, replication of the survey in A/NZ context and subsequent comparison of the results will prove valuable.

Gaps in the Literature

A lack of national literature investigating retention of OTs in general – and specifically in mental health makes it difficult to determine whether WFOT, USA, Australian, British and other overseas study findings are pertinent to A/NZ. The review identified a gap in New Zealand-based research studies specific to occupational therapy about retention or attrition of staff, with the notable exception of Lloyd et al. (2003). While this research was relevant to the literature review, it was the only A/NZ study that met the criteria. And, because the study was conducted in 2003, a current examination of the mental health workforce in A/NZ would be informative. There is a need for further research regarding the factors specific to A/NZ mental health occupational therapy. In addition, the work conducted at a global level by WFOT (Ceramides et al., 2009) did not include data from A/NZ therapists. A/NZ data would also be useful in understanding the work roles, tasks, future perceptions of the therapists.

Case management has been investigated in New Zealand (Lloyd et al., 2003) however; the influence of occupational therapy teams compared to occupational therapy sole positions has not been examined from a retention perspective. Also lacking is a recent study of A/NZ

mental health occupational therapists investigating the tasks involved in their roles (discipline specific versus case management) and whether common themes that affect retention exist.

Since 2000, there have been no mental health occupational therapy studies that look at past employees and their reasons for leaving at the time of exiting a position. As discussed previously, Bailey (1990a) looked at American occupational therapists in general no longer working as occupational therapists from all practice areas and considered their reasons for leaving. A confidential exit interview could be used to elicit information about reasons for leaving. Although Scanlan et al. (2010) and Hayes et al. (2008) both researched why individuals left past positions, they also reported that the reasons for leaving a past position may be viewed differently following departure compared to the time of leaving. Issues looked at retrospectively/ with hindsight can be seen with a different lenses or angle, and situations viewed with reflection, compared to when a person first left the position, indicate that some of the factors relevant at the time of leaving might now be viewed differently (Scanlan, et al., 2010).

Rationale for further study

Numerous factors have been identified in studies as playing a vital role in decision making; however, there is little known in A/NZ about which factors influence mental health occupational therapists. The literature review does provide occupational therapists working in mental health with evidence to support the factors that might influence their work as clinicians and provide a platform for discussion with management. The importance of personal and professional factors has been highlighted. Knowledge is power and so having the knowledge of factors that may have an impact on job satisfaction is important.

Research specific to the New Zealand mental health system must be conducted. We are unique in that our population distribution is different from other countries whose research has been reviewed. A/NZ has a unique cultural heritage and background that affects the way we practice as mental health occupational therapists. A/NZ was also quick to implement and embed the recovery approach into mental health services; thus our service delivery and philosophy make our services distinct.

Multiple issues investigated in this literature review that affect mental health occupational therapists could also be relevant to A/NZ OTs. Further research is required to establish key factors influencing retention of occupational therapists in A/NZ. A study into retention of A/NZ mental health OTs could address relevant factors that have a bearing on the future of mental health occupational therapy practice.

Increases in retention will increase productivity, client care continuity, experience and depth of knowledge within mental health occupational therapy.

As discussed in the introduction, managers and services would benefit from keeping occupational therapists in their services. This review and study's outcome could be used to develop strategies to increase occupational therapy's presence in mental health, affirm professional identity and support those working in the field as they become stronger practitioners. Management will be able to use the outcomes of this study to develop retention strategies specific to mental health occupational therapy in New Zealand.

With appropriate interventions, occupational therapists maybe more likely to stay in their positions or be more empowered to remain in mental health, ensuring knowledge and consistency of care are part of the culture and benefiting consumers of mental health services.

For occupational therapists, the research outcomes could be used to develop strategies to increase occupational therapy presence in mental health, maintain or improve professional identity and enable a stronger links to occupation no matter the OT's role such as case manager. Retention strategies are needed to retain occupational therapists in mental health, such as those described by Richards (1998).

Research Questions

As stated in chapter one, the purpose of this study is to identify the factors considered by occupational therapists working in mental health in New Zealand when making their decisions to stay/remain or leave their current, past and future positions and why?

After reviewing the literature, my interest is in whether a study specifically based in A/NZ would find similarities or differences in factors identified in overseas research on the issue of retention. Using job satisfaction as a proxy for retention, I have developed the following research questions:

1. What are the factors that A/NZ occupational therapists in mental health identify as influencing retention?

   1a. What are the factors A/NZ occupational therapists in mental health identify as influencing retention (job satisfaction) in their current position?

   1b. What are the factors A/NZ occupational therapists in mental health identify as influencing retention in past positions?

2. What are the factors A/NZ occupational therapists identify as influencing attrition?

2a. What are the factors that A/NZ occupational therapists identify as influencing attrition in current positions?

2b. What are the factors that A/NZ occupational therapists identify as influencing attrition in past positions?

3. What are the factors that A/NZ occupational therapists identify as influencing attraction into positions?

3a. What are the factors that A/NZ occupational therapists identify as influencing attraction into current position?

3b. What are the factors that A/NZ occupational therapists identify as influencing attraction from a current position?

CHAPTER 3: METHODS

Introduction

In this chapter, the reasons for the research design and survey development will be discussed. Validity and piloting, along with recruitment of potential participants, will be covered, and inclusion and exclusion criteria will be explained. Ethical considerations, data collection and analysis will also be considered.

To answer the research questions, a review of the research methods that would provide the necessary information was conducted. Although a qualitative design would have provided depth to an experience from a chosen number of participants' perspectives, a quantitative approach was instead selected. An online questionnaire survey was designed, as opposed to in-depth face to face interviews, as this would allow for comparisons of New Zealand data with overseas research and provide a comprehensive profile and view of the factors that New Zealand OTs consider when working in mental health.

Survey design and development

A quantitative, cross-sectional survey design was used to collect data. A national online survey was chosen because this method of collection more adequately covers the geographical distribution of the study's population (Sue & Ritter, 2012). In addition to this benefit, online surveys can be low cost (De Vaus, 2002), increase the speed of returns compared to other survey methods (e.g. post), self-paced, and they may allow for more honesty because the researcher is not present (Sue & Ritter, 2012). Challenges of an online survey are technology needs (suitable computer access) and the increased number of survey invitations in a person's email inbox (Creswell, 2014). Still, the advantages of an online survey for the purpose of this research justify the method's use. Regarding analysis, the data can be directly imported and the data can be received in a usable form relatively quickly (Forsyth & Kviz, 2006).

A cross-sectional survey design allows for the useful/ effective measurement of a sentiment or factor in a particular aspect of time; however, it does not measure a change over time (Pallant, 2007) and does not allow for the establishment of causal relationships between variables, yet it can provide information about such factors (Piko, 2006).

This study's 37 item survey was constructed to reflect the concerns and findings found in the literature about the topics of turnover, job satisfaction, attrition, and retention. Following the literature review, the researcher used professional contacts to obtain 3 Australian surveys--

Hayes et al. (2008), Scanlan et al. (2010), and also Scanlan and Still (2013). These formed the basis of the survey to allow international comparisons between A/NZ data that would be collected and the data of other countries. Over 10 research articles (See Appendix B for the survey development table) were analysed, and some of the items and factors used were included as part of the selection of questions, possible factors, and options for participants. To incorporate a range of miscellaneous factors not included within other surveys mentioned above, a list of factors was drafted and then checked off to ensure they were either already included or added as an item to a question already set up. For some questions in the current survey, the list of other factors identified by the literature responses was included. At times, factors were aggregated and added to those already developed. Overlap in categories

To note, factors in tables (for example, Q.40 in Appendix C, Table 19) were developed from previous literature and research results. When reviewing and consolidating the factors during the survey development, there was a decision made to not consolidate some factors in order to be able to compare with previous results and literature. Although it may be perceived that there is an overlap of categories which may complicate the interpretation of factors identified by participants, in order to make a direct comparison with previous research results, some factors were not merged.

As a result, the content of the current survey is directly related to the literature review, and much of the wording of the survey has been specifically selected to replicate previous results and enable comparisons of results. Close-ended questions were used with in conjunction with an ‘other' option to elicit additional information. The survey itself collected demographic information, the nature of the position in mental health, daily tasks, roles, and responsibilities. The participants were asked about their satisfaction, views on current and past positions from positive and negative experiences, and attraction to positions. Participants were also asked about their models of practice. Refer to Appendix C for the master copy of the full survey.

As a result replicating questions, items and format from elsewhere, any validity issues were determined by previous studies and Scanlan and Still (2013), Scanlan et al. (2010) and Hayes et al. (2008). Validity is the degree to which the item measures what it is supposed to measure (Graham, 2009).

Survey development support

Stuart Terry at Otago Polytechnic, an organizational researcher with extensive experience in online surveys was consulted throughout the study's implementation. The 'Qualtrics' online survey system was used due to the support that could be provided and the length of the survey. Another survey option, Survey Monkey, could not be used as a free version for surveys needs less than 10 questions. Stuart reviewed the survey, gave suggestions and worked with the researcher on data collection and collation. OTBNZ was consulted on the number of occupational therapists, defined as current Annual Practicing Certificate (APC) holders that have reported working in mental health. Dr. Justin Scanlan, who has conducted two relevant surveys in Australia and numerous research studies with mental health staff in Australia, was contacted and has participated in on-going discussions about the issues and limitations of this survey design.

The survey questions were initially typed into a word document and passed onto the organisational researcher for formatting into 'Qualtrics.com'. After drafts, amendments and initial discussions, the researcher obtained access to the online Qualtrics system with administrative and editing rights. This allowed the researcher to enter the survey and make changes to the questions, format, and design with the support of the organizational researcher. The questions were numbered (e.g. 1,2,3) for reference and additional analysis. For the purposes of reference while reading, a question number appeared next to a heading throughout the text of the survey (e.g. Q.38). The master list of survey questions can be viewed in Appendix C. In some places, the numbering is not in numerical order, as questions were moved during testing and piloting. However, in the final and live survey, no numbering for each question was present, but instead a bar on each page indicated how far through the survey the participant was (see an example of a snapshot of a Qualtrics question online, Appendix D).

Piloting and validity

To establish face validity and to ensure that the survey instrument was comprehensive, the researcher undertook 3 different piloting phases with 12 people in various stages of development. The paper version of the survey was reviewed by 2 occupational therapists in management positions before the data was entered in Qualtrics. As part of the trialing and face validity, 5 people were asked to complete the survey through Qualtrics online. One of the pilot OTs is part of the Maori Roopu group and also on OTNZ-WNA board. The design and questions were modified from the comments and concerns of those who piloted the survey. Answers were reviewed and panellists were asked questions verbally in slightly different formats to judge whether responses were the same. Initially, a series of questions asked

participants to rank 1-5 as their main answers from a list of 20-30 factors. However, it became evident that the time spent on such a survey was longer than the recommended 15 minutes. The design was changed to a Likert scale for each factor that could be viewed on more than 2 pages in the system. Small modifications from the replication of other surveys were made to ensure that the language was relevant to the New Zealand context and health systems.

Recruitment and survey procedure

Recruitment

Potential participants were recruited in several ways. First, OTBNZ and OTNZ-WNA were contacted to obtain ethical consent for the research in order to use their contacts for dissemination. Both of these organisations have established internal screening processes to ensure that ethical issues are addressed. The approval by Otago Polytechnic Ethics Committee was required before the researcher could ask these agencies to advertise the survey through their networks.

According to the 2016/2017 APC data (OTBNZ, 2016), OTBNZ has 343 registered occupational therapists currently practicing who identify as working in mental health and have consented to be contacted via email about research participation invitations (Juanita Murphy, personal communication, January 21, 2016). This information provides a good sense of survey coverage, although the number who did not consent to be contacted was not available.

Following ethical consent review and screening processes, OTNZ-WNA sent the information for the survey via the special interest groups of mental health and the issues forum.

The School of Occupational Therapy, Otago Polytechnic Facebook page featured the survey invitation. People who viewed the invite were actively encouraged to share and send it on to their occupational therapy colleagues and contacts. Snowball sampling works well in a small population where members may have contact with one another (Sue & Ritter, 2012).

A Prezi card draw inducement/ incentive was offered. Material incentives can add to the response rates (De Vaus, 2002). Participants were encouraged to join through entry in a random drawing for one of two $50 Prezi cards. The drawing was advertised on the invitation and the participant information sheet. Participants who completed the survey were asked to volunteer their contact details at the end of the survey if they wished to enter the draw. It is clearly stated that this information will not be attached to the survey data but instead will be removed by an independent person (Stuart Terry) before data is collated and given to the

researcher. The independent person selected the prize winners using a random number generator.

Inclusion and exclusion criteria

To be eligible, the participant needed to be a registered occupational therapist with OTBNZ. As this was the first question on the survey, those participants who answered 'no' were not eligible to continue with the study. The second question of the survey asked if the participant currently worked in mental health services in New Zealand. Again, if the participant answered no, they were not eligible to continue with the survey. The exclusion criteria were made up of the opposite of the inclusion criteria: not qualified as an occupational therapist, not working in New Zealand, and not currently working in mental health services in New Zealand or with clients who experience mental health issues. The survey removed participants from the study when no answer was provided to these questions.

Ethics and consultation

Ethics approval was sought and approved by Otago Polytechnic ethics committee (See Appendix E for Approval Letter). In addition, ethical consent/ approval for the dissemination of invitations was requested from OTBNZ and OTNZ-WNA to enable the researcher to use their mailing lists as part of the call for participants. Each year, OTBNZ asks occupational therapists on their APC if they can be contacted for research purposes. As part of being a member of the association, the forums and lists are able to be used to disseminate research requests to other members.

Occupational therapists are not usually considered a vulnerable population. As professionals, they were asked to complete the questionnaire anonymously. However, should any issues arise, they were advised to contact their supervisor, Employee Assistance Program (EAP) scheme or general practitioner (GP) for a referral to services if the survey raised any personal issues. The survey (see Participant information sheet, Appendix F) explicitly stated that, as an online survey, once the survey has been completed, the data cannot be withdrawn. It is also made explicit that participants' anonymity is assured. No names or contact details were returned to the researcher with the data (as people could indicate a willingness to be part of an interview, which is not part of this thesis). An independent person (organisational researcher) collated the results to ensure participants could not be identified by the researcher. A survey/ questionnaire also offers greater anonymity and therefore an increased likelihood of obtaining valid information from potentially sensitive questions (Sue & Ritter, 2012; Kumar, 2011).

The following section outlines the ethical principles considered for a survey design and applied to this study. As part of occupational therapy competencies, OTs are bound by the Code of Ethics. The following principles are relevant and were considered during survey, data collection, and analysis.

Informed consent

Informed consent must also be obtained to collect and release information relevant to the participants' involvement (OTBNZ, 2015). Survey participants were told that their informed consent was being given by clicking on the submit link in the online survey. The following information was presented to potential participants prior to beginning the survey. Potential participants were sent an email invitation (see Appendix G) that provided information about the study and a link to the survey. After clicking on the link, the first page of the survey contained further information and a link to a participant information sheet (see Appendix F). Both the email and the survey contained a clear statement requesting their involvement in the study and an explanation of the purpose of the research and how the data would be used. Participants were informed that they could withdraw from the survey at any time up until they clicked the submit button at the end.

Cultural consultation and considerations

The ethics process mandated consultation with the Kaitohutohu (KTO) office at Otago Polytechnic. The Kaitohutohu Office (KTO) of Otago Polytechnic supports the implementation of the 'Maori Strategic Framework' across Otago Polytechnic, with research being part of that framework. KTO was contacted and correspondence sent. The study was approved by Justine Camp from KTO on 26/2/2015:

> "Your responses are well considered, thank you for collecting the data. At this stage we only have one team member able to undertake the work so if you require Māori support can we suggest you approach the Māori OT collective? In addition to having a Maori world view, they also have an OT worldview so you are lucky in that they can give you sound advice on any Māori aspects of your project"

In response to Justine Camp's suggestion to consult with the Maori Roopu, both Karen Molineux and Sharon Harth Bryant were initially consulted. Neither worked in mental health (but Sharon had prior experience working in mental health), but they did provide feedback about the survey on behalf of the Maori advisory group.

The information from participants includes information about ethnic identification. After feedback from KTO, a conversation was conducted with a member of the Occupational Therapy Roopu. The research was discussed, and it was decided to specifically include OTs who identify as Maori in the pilot. When the responses were calculated for the full survey, it we found that a small minority of OT's identified as Maori (15 participants- 6%). This information was not filtered separately and analysed to allow participants to remain anonymous.

Anonymity and confidentiality

The organisational researcher collated the survey data at Otago Polytechnic and removed all identifying information. This information is potentially sensitive and its removal improved the confidentiality and anonymity of participants with respect to the researcher given the likelihood that she would know some of the participants. The de-identified data will be stored for 5 years in a secure location at the Polytechnic, after which time it will be destroyed and deleted.

The survey clearly states that the information is collated, analysed and reported anonymously and that people will not be personally identified in any reports published as a result of the survey. It was made explicit that comments and feedback are also completely anonymous.

Sharing and disseminating the results

A summary of the research will be sent out via the OTNZ-WNA mental health special interest forum, and a link will be made available via the Otago Polytechnic School of Occupational Therapy Facebook page. Data may be used for conference presentations and submitted as articles to academic and professional journals.

Data collection

As previously mentioned, the online survey service 'Qualtrics.com' was utilised, as the researcher was involved in another research project that used this online survey system. The survey went 'live' in April/ May 2016 and was open for 3 weeks. As discussed above, invitations were sent out, and a closing email was sent out via the same avenues after 2 weeks (see Appendix H).

During the initial data analysis in excel, it was noted that some participants failed to complete the full survey. This was not unexpected with an online survey (Sue & Ritter, 2011). During

the pilots, some questions were reworded and the format was changed to ensure the survey was as clear and concise as possible. The basic completion time was 15 minutes. Some pilots initially took over 30 minutes when the Qualtrics system used flow and display logic depending on the answers to previous questions (yes, to Q 3, 'No' to Q 5). This can sometimes be referred to as 'zoned out' or 'zoned in'. Upon reviewing the key variables, all respondents who answered the forced-choice questions (Q. 3 and 4) were eligible to progress and needed to answer at least 10 of the first 20 questions to be included in the analysis. This was to ensure that their information would add to the depth of information needed to create comparisons and contrasts with section 2 of the survey. A second initial scan analysis was completed for those who answered 'satisfaction'- Q 38. This was an important outcome variable for analysis. If a person had not answered satisfaction, (this was 28 people) then their responses from question 38 were excluded but their demographic and working life information has been used to add to the richness of data.

Beyond responding to satisfaction, participants were able to answer questions relating to past, present and future positions and corresponding pushes, pulls or attractions. A further 4 people were excluded because they did not respond to questions beyond satisfaction, making n= 202.

Analysis

Cleansed data was provided to the researcher in a format that enabled descriptive, comparative and inferential statistics to be used in the analysis. As part of the analysis, comparisons have been made to other research.

The responses were analysed descriptively, and the open-ended questions (or 'other' responses) were analysed using themes or factors and cross checked by supervisors and subject area experts (e.g. Models of practice). The themes and factors were used as coding categories (Polgar & Swerissen, 2000), and the responses were categorized according to the theme codes and then counted.

For a number of questions, although the survey asked for participants to round their responses to the nearest year, anomalies occurred, such as '.5' or '6 months' responses in the text boxes. A rounding system was used when participants were asked for the nearest year in the question list, such as number of years worked as an occupational therapist, years worked in mental health, and years in the position prior to current position (refer to the Appendix C for master list of survey questions). Statistics New Zealand often rounds some of their information to the nearest year. If a person has been working in positions 6 months or above, then that would be recorded as one year, if less than 6 months, then 0. Due to the volume of participants, the rounding worked well for analysis purposes.

Cleaned data was provided to the researcher in an Excel spreadsheet format that then enables descriptive, comparative and inferential statistics to be conducted within SPSS 24 (IBM Corporation, 2016). In this study Pearson's Product-Moment Correlation Coefficient analysis (R) with a bivariate analysis were conducted. This enabled two of the questions to be analysed to ascertain the strength of the relationship between the dependent variable of job satisfaction and participant's views of their current position.

The data allowed for the identification of associations, similarities and differences between therapists in A/NZ and other international populations.

CHAPTER 4: RESULTS

Response Rate

The survey link was opened from an online introductory invitation by 283 people, with 274 people proceeding to the first question. The survey contained two forced choice questions (the first two (2) questions of the survey), with both serving as inclusion criteria for eligibility. In the first forced choice question (Are you currently working in mental health services in New Zealand?), 237 people answered 'yes.' Thirty-seven answered 'no' and thus were not eligible to complete the remainder of the survey.

Of these 237 people who reported working in mental health in New Zealand, 234 confirmed they were registered with the Occupational Therapy Board of New Zealand. Thus, 234 participants met the initial inclusion criteria and were eligible to proceed to the remainder of the survey. Table 1 shows the questions, description and flow of the initial phase of the survey eligibility.

Table 1: Description of Participants in Initial Phase of Survey

Opened link to survey from invite		283
Opened up link to survey and proceeded to answer 1		274
Q 3: Are you currently working in mental health services in New Zealand? (forced choice- inclusion criteria)		
n= 274	Yes	No
	237	37
Q.4: Are you registered with the Occupational Therapy Board New Zealand (OTBNZ)? forced choice- inclusion criteria) Eligible to proceed to this question: n= 237		
n= 237	Yes	No
	234	3
234 eligible to respond to rest of survey. 234 participants are approx. 68% of OT's who identify as working in mental health.		

There were 2294 occupational therapists who possessed an APC in New Zealand (OTBNZ, 2016), so the 234 eligible participants make up 9.8 percent of the OTs working in NZ.

In the breakdown of employment roles in the annual report (OTBNZ, 2016), 15 percent of OTs identified as working in mental health (344). On this basis, we can assume that the survey has captured 68 percent of OTs views of working in mental health, bearing in mind a

limitation in determining the actual number of OTs working in mental health. This limitation cannot be quantified, but on the APC documentation, a person can choose a category. For example, in the APC documentation, 6 percent of OT's identified as working in management (unable to assume what field this is management in) and in relation to the paediatrics as a field, which could be for example, Child and Adolescent Mental Health Services (CAMHS) with paediatrics or early intervention mental health. Ceramides et al. (2009), in their worldwide study for WFOT, also reported that OTs working in mental health often identify themselves as 'paediatric OTs' if they work with children rather than as mental health OT's. OTBNZ (Juanita Murphy, personal communication, 30 April 2016) could not confirm the exact number of mental health occupational therapists due to the options on the APC paperwork and ambiguity in selection by OTs. Bearing this in mind, the rate of return is still high for an online survey.

After the initial two forced- choice questions (which placed a restriction on those who could continue on to the rest of the survey), the remaining questions were unforced (did not require answers) allowing participants to proceed by choosing which questions they completed. Those prevented from moving on to the rest of the survey were taken to a 'Thank you' message stating they were not eligible to continue with the survey (see Appendix C within the master survey questions for the message to people who did not meet the criteria).

For the majority of the questions, participants were able to respond with more that one factor from the list or use the 'other' and type in a response (see Appendix C. For example, 'Q31 What other benefits/perks do you have as part of your position? Please select as many as applicable'. This means that the N= is the number of participants who responded whereas the total number of responses refers to the number of factors chosen by the participants.

Participants

Geographical location

Participants were assured of their anonymity concerning their participation and the confidentiality of their responses. During the survey development phase, researchers were unsure of how geographically variable the response rate would be. As this was a nationwide survey, it was necessary to ask about geographic location to ensure that the spectrum of New Zealand was covered. However, if too few people responded to the survey in each area, then it might be possible to identify participants using their responses to other questions. For this reason, to maintain anonymity, areas were aggregated to wider regions. The breakdown of the

geographic areas with aggregated categories can be seen in Fig. 2, (see Appendix C for master survey questions).

Of the 234 participants eligible to take part in the survey, 233 participants answered the question pertaining to geographical location. Auckland/ Northland had the highest number of responses with 79 (34%), followed by Waikato/ Bay of Plenty with 47 (20%).

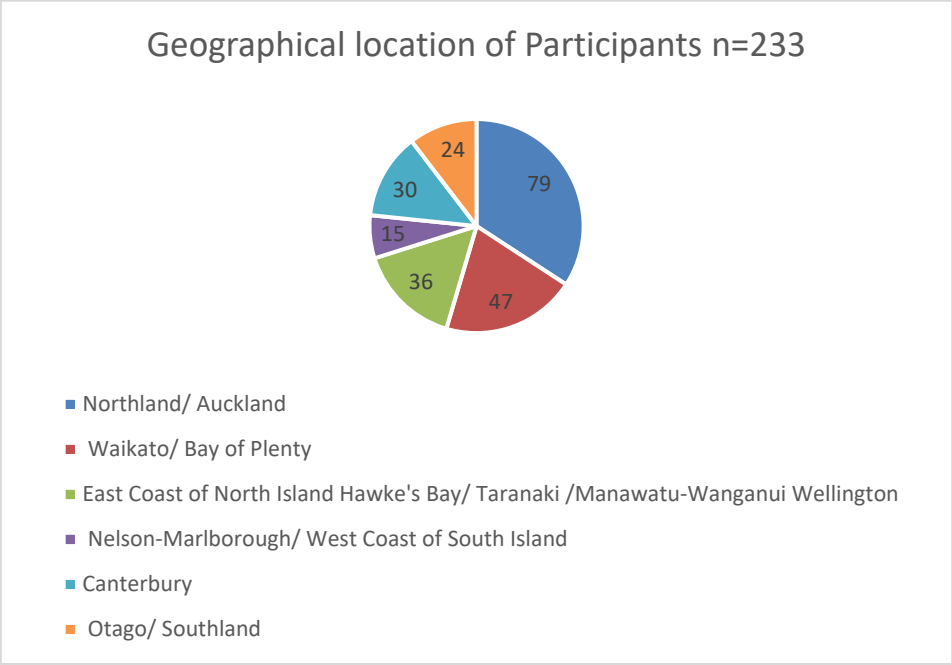

Figure 2: Geographical locations of the participants

In order to compare data to Health Workforce New Zealand (Ministry of Health, 2016a), the participants were aggregated into the '4 DHB regions' shown in Table 2.

Table 2: Geographical Locations of Participants According to Health Workforce Divisions

Geographical location	Aggregated Data from survey n= 233	%
Auckland, Northland	79	34%
Waikato, Bay of Plenty, East Coast of Nth Island, Taranaki	47	20%
Hawkes Bay, Manawatu/ Wanganui, Wellington	36	15.5%
Nelson/ Marlborough, West Coast of South Island, Canterbury, Otago, Southland	71	30.5%

Ethnicities

Participants were asked to identify which ethnicities they most strongly identify with. Participants were allowed to select more than one ethnicity, with 17 people selected 2 categories and a total of 250 responses.

Ranking the highest ethnicity, 190 participants identified as New Zealand European, 21 UK European, 15 NZ Maori (6%), 9 South African (4%), 8 Asian, and 4 Pasifika (2%), with 3 other (incl. Australia).

Using the Statistics New Zealand (2005) categorisation of level 1 and combination ethnicity categories, Table 3 identifies which ethnicity participants identified with and the combinations. With New Zealand (European) rating the highest and only a small percentage of Maori and Pacifica, these statistics will be of interest to those recruiting into occupational therapy. As discussed in the survey development phrase, people who identify as Maori have not had their responses separated from others in the analysis. However, the issue did need to initially be addressed, because New Zealand has a mandate to the indigenous people of Aotearoa New Zealand, through the New Zealand Maori health strategy and framework of He Korowai Oranga (Ministry of Health, 2014) and 'For Maori, by Maori' services such as through Whanau Ora programmes (Ministry of Health, 2014).

Table 3: Ethnic breakdown of the participants according to Statistics New Zealand (2005) recommendations

Ethnicity breakdown	Number (n=233)	%*
Maori only	7	3%
New Zealand (European) only	176	75.6%
Maori/New Zealand	8	3.4%
NZ European/ Other	6	2.5%
Pacific/ other	3	1.2%
Pacific only	1	0.04%
Asian only	7	3%
Other only	23	9.8%
Other combinations	2	0.08%

*Percentages do not total 100% due to rounding.

Current age ranges of OTs working in mental health in New Zealand

Of the 234 eligible participants, 232 responded to the question of their age. Of those who responded to this question the greatest number of participants (35, 15%) were aged between

36-40. There was a relatively even distribution between the ages of 31-35 (13.4%) and 41-45 (14.2%). The distribution of ages for participants can be seen in Fig 3. There is a decrease in numbers of OT's working between the ages of 26-30 in mental health services and then an increase in the 31-35 age bracket. The average age of an OT working in New Zealand is 42 (OTBNZ, 2016). For this survey, average age range was on the cusp of 35-40 and 41-45.

When compared with other occupational therapy workforce surveys, one study based on New Zealand mental health OTs (Lloyd et al., 2003) showed 36.5% between the 31-40 age bracket (this survey, 28%) with 17.3% between 41-50 (this survey, 26.7%) with 10.9% over 50 (24.6% this survey). Scanlan and Still (2013) had a smaller sample, but almost half their participants were in the 30 or less age bracket (47.1%), whereas the peak in this study was in the 36-40 bracket. This study has a more gradual, linear distribution of OTs working in mental health than the previous New Zealand study, with more OTs in the older age brackets.

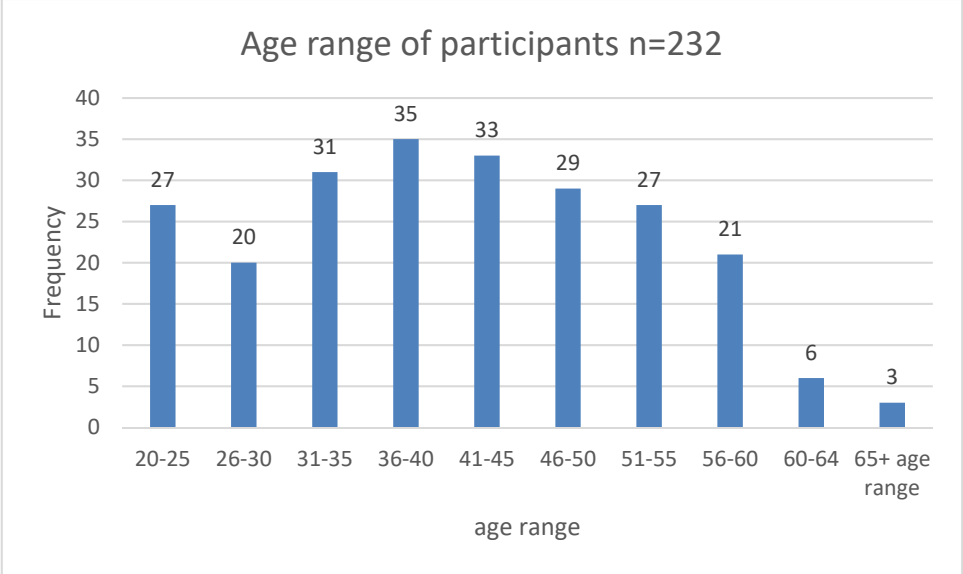

Figure 3: Age range of participants

Gender

In response to the question asking which gender participants identify with, 163 responded. 150 (92%) identified as Female, and 13 (8%) identified as Male.

The survey figures are a reflection of the make-up of occupational therapists in New Zealand, with the OTBNZ annual report (2016) reporting that females make up the majority of the profession. 92 percent of APC holders identify as female and 8 percent as male.

The response rate of 69.7 percent (163/234) of respondents was low compared to the overall survey numbers. The gender based question was question 5 on the survey. Question 6 had a response rate of 227, while question 4 had a response rate n = 233. It has now been

determined that there was a glitch in the online survey system for this 'gender' question during the first 48 'live' hours of the survey. To comply with ethics, the researcher could not access the Qualtrics system, so the glitch was subsequently rectified by the organisational researcher.

Summary of Demographics

Of the 234 survey participants, 92 percent identified as female with 8 percent identifying as male. The survey captured participants from the majority of New Zealand, with the highest percentage in Auckland/ Northland (34%), which is to be expected given the population distribution of New Zealand (Statistics New Zealand, 2015). The average current age range for occupational therapists was 36-44 (highest percentage at 29.3%). The largest ethnic group working in mental health services in New Zealand were New Zealanders (European) with 75.6 percent; those who identified as Maori and New Zealand (European) were at 3.4 percent and Maori at only 3 percent.

Working life: Work of the participants

Year of Qualification

The year of qualification as an occupational therapist ranged from 1966 to 2016. It is unknown if participants listed the year they finished their course (usually November) or if they listed the year they qualified with the OT board (January of the following year). The average year of qualification in the current survey was 2001 (15-16 years of qualification). In comparison, the annual report from those who have APC with the OTBNZ listed the average number of years of practice by occupational therapists with APC as 14.1 years (OTBNZ, 2016), relatively close to the survey average.

Years of work due to OT qualification

In a text box on the survey (Q. 12), participants recorded how many years (rounded to the nearest year), they had worked due to their OT qualification. The average number of years of work with OT qualification was 13.43 years across the 225 responses from participants. This figure included those working in jobs with a title other than an occupational therapist, with or without an APC. This is a higher average than Scanlan et al. (2010), who reported 7.7 years.

Table 4: Age range of participants

Years of working since qualifying	N= 225	%*
0-5 years	72	32%
6-10	36	16%

11- 15	25	11.1%
16- 20	37	16.4%
21- 25	19	8.4%
26- 30	20	8.8%
31-plus	16	7.1%

*Percentages do not add up to 100% due to rounding.

Of note, 15 (7%) participants were new graduates (within their first year of work), with 32 percent within their first 5 years of work. This information will prove interesting to consider in the future, where years of work could be compared to factors affecting retention and attrition. As shown in Table 4, the years have been aggregated into 5-year increments.

Length of time working in mental health

Of the 226 people who responded to the question (Q.13) about the number of years worked in mental health services, 79 have been employed in mental health for 5 or fewer years. 5 have worked in mental health for more than 30 years. The average number of years working in mental health for the 226 participants was 10.8 years. This average was double that of Scanlan et al. (2010), who reported an average of 5.8 years. Of note, of the 72 participants who identified as being in their first 5 years of practice, 29 are considered new to the field, reporting 0-1 year of practice in mental health. Because only 15 participants identified that this was their first year of working in mental health since gaining their OT qualification, this finding suggests participants had potentially moved from another field into mental health. Fig. 4 depicts the number of years participants have worked in mental health.

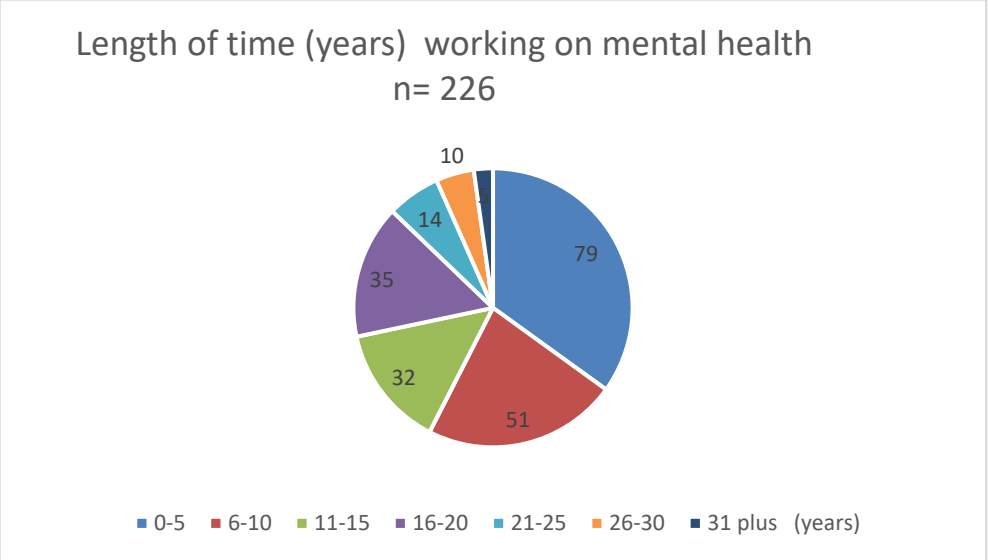

Figure 4: Occupational therapist's years of working in mental health

Number of positions held in mental health

The average number of positions respondents have held in mental health is 3.8. The greatest number of positions in mental health was 18. Fig. 5 illustrates the distribution of participants' number of positions in mental health. Of the 199 respondents, 27% are in their first position in mental health.

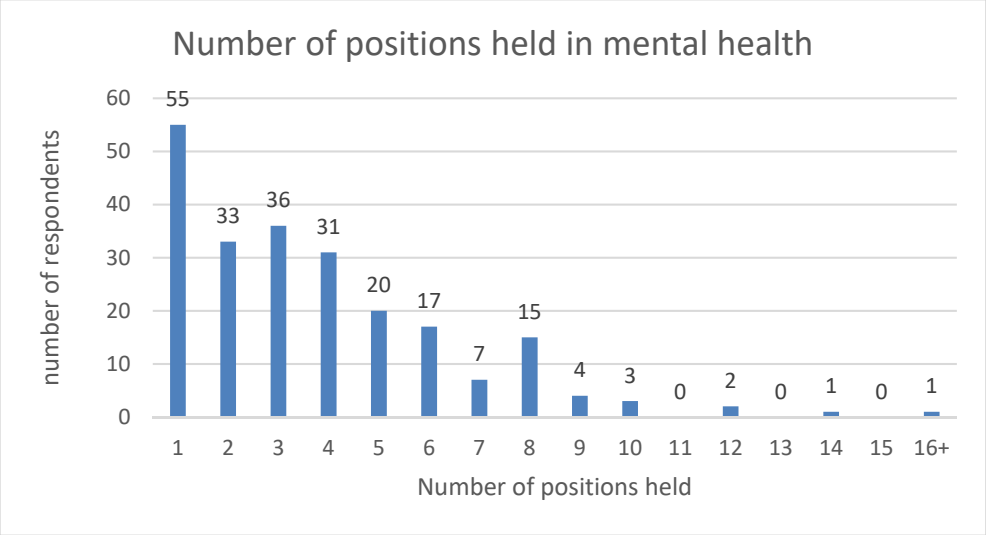

Figure 5: Number of positions held by OT's in mental health

Current Position- Duration in current mental health position- Length of time

Of the 223 respondents, 11 have been in their current position for over 15 years. 152 have been in their current position less than 5 years, with 69 people (29%) in the first year of their current position. The average number of years in their current position is 4.4 years.

Previous positions- how long in past position- length of time

This question was 'seen' on Qualtrics only by those who had reported holding more than one (1) position (Q. 14). Of the 197 eligible participants, the average number of years in past positions was 3.5 years. The number of years in previous positions ranged from 1 to 20. Previous positions were not necessarily mental health positions.

Annual Practising Certificate

Of the 225 participants who answered the question (Q.17) 'Do you hold a current Annual Practicing Certificate (APC) with the Occupational Therapy Board of New Zealand (OTBNZ),' 222 answered 'yes,' and three (3) participants answered 'no.' This was not a forced choice question- the respondent did not need to either answer or give a 'yes' response to proceed to the next question of the survey. Of the original 234 eligible for the survey, along with the 3 who gave a no response, a further 9 elected not to answer this question, indicating there were potentially 12 respondents who were working as occupational therapists

but do not hold APC. This is significant for the OTBNZ to be aware of to facilitate yearly APC reminders and audits.

Summary of working lives of participants

The average number of years since qualification as an occupational therapist for participants was 15-16 years, with the years worked due to OT qualification at 13.43 years. The average length of time working in mental health was 10.8 years, with the average number of positions in mental health at 3.8 positions. The average time participants have spent in their current position is 4.4 years, and the previous position to this position average length was 3.5 years. As occupational therapists, all participants should hold an APC, however, the survey produced ambiguous results for about 12 participants, and three (3) stated they did not possess an APC. This does not affect their participation in the survey, but to use the title of occupational therapist, people must hold an APC (Juanita Murphy, personal communication, May 20, 2016).

Current position in mental health

Employers/ Sector employment

There were 232 responses given from 224 participants (who were permitted choose more than one category) to identify who they worked for (Q.18). The majority of participants worked for District Health Boards (DHB) n= 170 (76%), with 35 (16%) working for Non-Government Organisations (NGO). OTBNZ (2016) reported that 49% of OTs worked in DHB and 7% in NGOs (for all areas of practice), indicating that the current survey is over represented by these areas. In the current survey, 16 participants identified as working in private practice, with the remaining 11 responses across Primary Health Organisations (PHO), Needs Assessment Services, Non-Profit Organisations, government agencies, training establishments and the education sectors. The responses to the question required extensive coding to demonstrate that participants work in a wide range of fields. The categories are shown in the Fig. 6. The researcher was unable to establish the full-time equivalent (FTE), so no comparison could be made using New Zealand health workforce data.

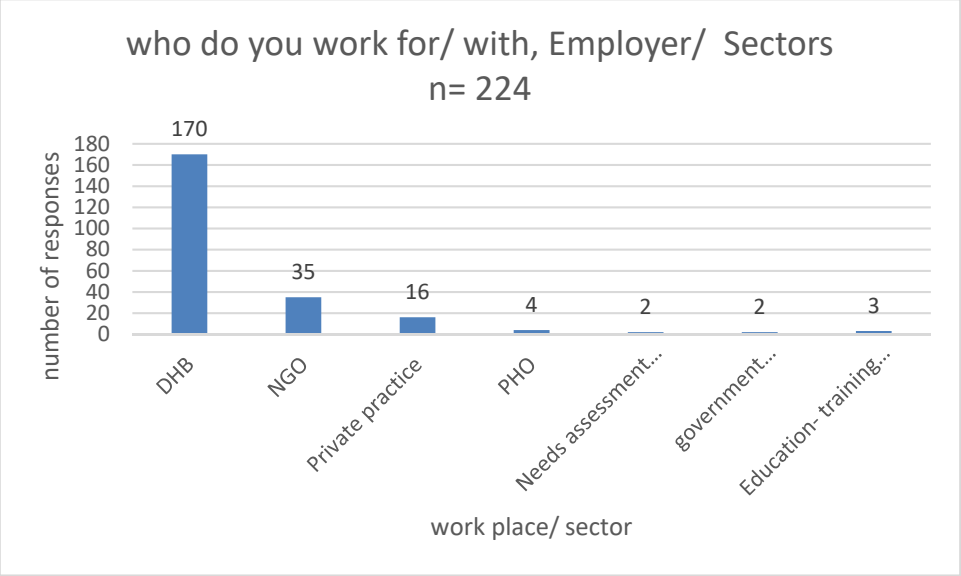

Figure 6: Participants employers/ sectors of work

Client demographics

The clear majority (73.8%) of the participants worked with people between the ages of 26-64. This age bracket is deemed as part of the adult service. The client age group aggregation on the survey was based on the usual age division in the DHBs. Although the researcher was unable to find explicit information about how age ranges were delineated, there is some background evidence to show these ranges; including the New Zealand Public Health and Disability Act (2000) and the strategies in subsequent years, such as the New Zealand Health Strategy (Ministry of Health, 2016b). There is also a funding division according to the Ministry of Health(2016d) Vote Health and funding allocation, the Ministry of Health (2016c) documents on population based funding, and census material (Statistics New Zealand, 2015).

With 385 selections made by the 225 participants, the analysis showed that OTs work across age groups. Considering that some OTs identified more than one category, 'infant, child and adolescent' and 'older persons' categories both shared similar numbers, at approximately 25 percent. According to the OTBNZ (2016), 17 percent of OTs work with children, 19 percent with adolescents, and 19 percent with older persons. The number of OTs working in adult mental health who participated in the current survey (77.8%) was substantially more than OTs in any field working with adults- 46 percent according to the OTBNZ annual report (2016). With what the researcher knows of the onset and progression of mental health issues for adults, such as schizophrenia, and evidence from Chapleau (2017), the onset is approximately 18 years old. Therefore, the number of OTs working in adult mental health services is not unusual, yet there is a demand for adolescent mental health OTs. There is evidence to back up

that if early intervention is undertaken, there is a positive impact on mental health understanding and improvement in mental health later in life (Kelly, Jorm & Wright, 2007). With an increase in aging population in New Zealand (Statistics New Zealand (2015), we would anticipate a rise in the number of OTs working with older persons in mental health. Ceramides et al. (2009) back up the current researcher's reasoning, finding that the majority of the occupational therapists work in adult mental health, yet the aging world population and the rise of dementia (Ministry of Health, 2015) may cause service allocations to change.

In Table 5, the demographic data of the clients that participants work with is shown. The first columns as per the survey categories of age groups, whereas the second column represents the aggregated data as 'adult mental health services' is defined as the age bracket of 18-64.

Table 5: Demographics of Clients that the Participants work with in Mental Health Services

	As per survey division		Aggregated data	
	n= 225	%	n= 225	%
Infant, child, adolescent (under 18)	58	25.8%	58	25.8%
Young adult (18-25)	105	46.7%	175* (18-64 age)	77.8%*
Adults (26-64)	166	73.8%		
Older persons (65+)	56	24.9%	56	24.9%
Total responses	385		289	

*aggregated data using total in Adult mental health services age bracket

Team/ Setting

Participants were asked 'In which team and setting do you work with the clients? (please indicate all areas and give an estimated percentage % of your total work time. The total should add up to 100%)' (Q. 21).

Participants could and did write percentages across a number of the options given. The researcher was able to scan the data and note that some participants had worked out their percentages, while others had used different methods of recording their responses, but during the analysis, the researcher was unable to depict the responses to show meaningful results. However, results regarding the number of people working in the areas of practice, as opposed to the time spent in specific areas, are provided In doing this, we were still able to provide (or identify) significant meaningful areas of work.

There were 338 responses to the question about team/ setting from 225 participants (n= 225). The number of participants working in particular teams/ settings can be seen in Fig. 7.

The highest number of participants work in community continuing care (21.7%), community rehabilitation (21.3%) and acute inpatient (19.6%). The lowest number of participants work in first episode psychosis (FEP) teams (4). These practitioners may identify as working in child, youth and adolescent services or CAMS (7), a specialist service, or early intervention service (10), as opposed to the term FEP.

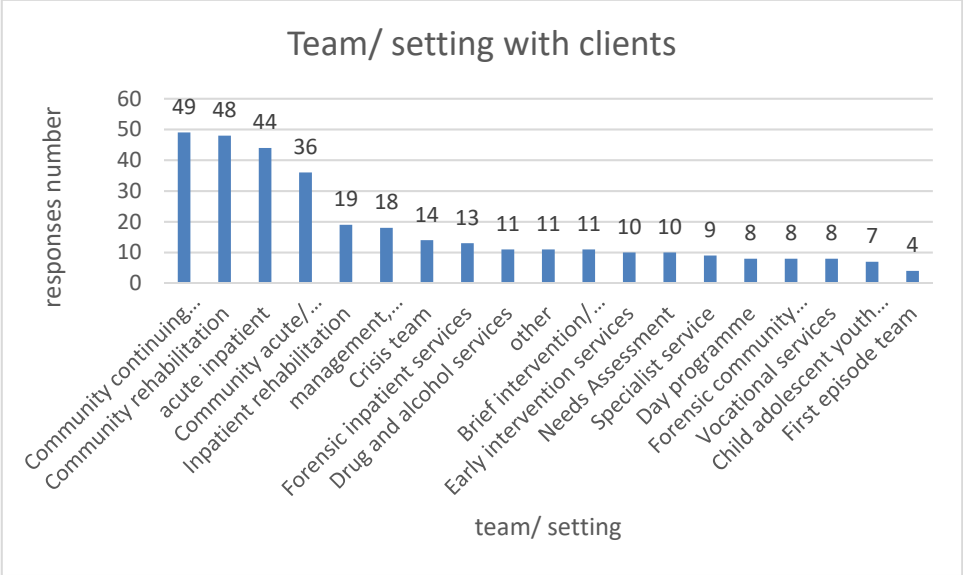

Figure 7: Participants areas of practice in mental health services

Please note this analysis does not depict the time spent by participants in each area (as originally intended), but rather shows if/ what work is conducted in a particular team/ setting.

Job Titles

When asked about job titles (Q. 22), of the 220 responses, 131 (59.5%) participants work under the title of 'occupational therapist', while the title of 'keyworker' or 'case manager' is used by 19 (8.6%) of participants, along with management/ manager in 19 responses (8.6%). Fig. 8 shows the range of titles and numbers of participants with the title.

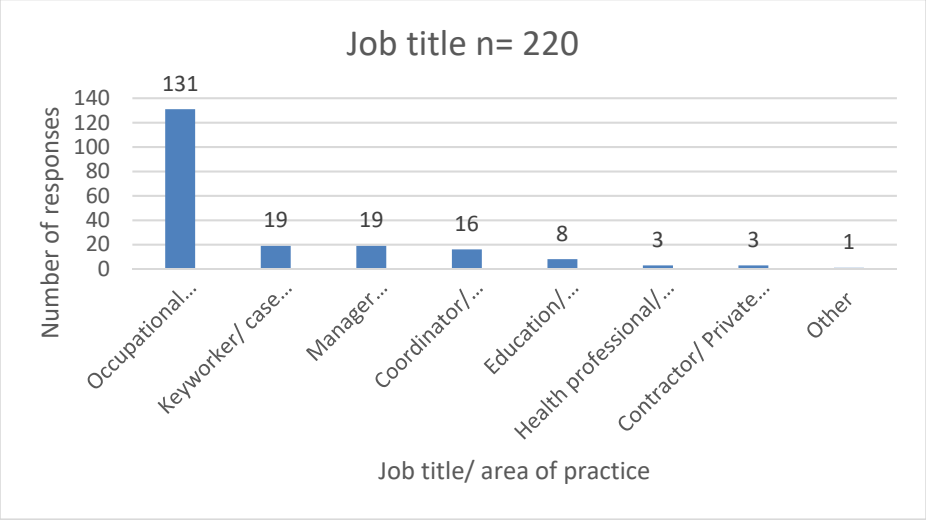

Figure 8: Job titles of participants

Discipline vs generic position

Over half of the participants, 138 (62.4%) of the 221 responses, reported that their role included half or more of their position involving generic work (Q. 23). Of the participants, 45 (20.4%) reported their work as almost completely discipline specific. 33 (14.9%) of participants reported work as almost totally generic in their position. This distribution is similar to that of Scanlan and Still's (2013) study. Although Lloyd et al. (2003) used a different measure, 51 percent of the participants in their New Zealand study had significant case management roles (generic work). Although the researchers compare their results with caution, this shows that there has potentially been a slight increase in generic work over the past 14 years. Fig. 9 shows the distribution of participants in relation to the discipline specific and generic work.

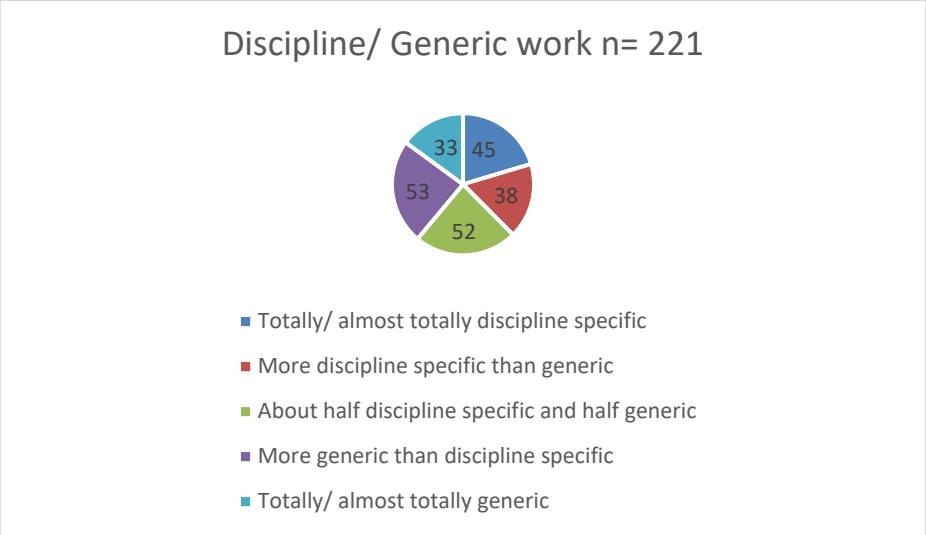

Figure 9: Types of work of participants discipline specific vs generic work

Hours per week participants generally work

Of the 204 participants, the majority, 132 (64.7%), of participants worked 40 hours a week. Those not working 40 hours a week split evenly between 2 categories- 20-30 hours a week and 31-39 hours a week, with 28 (13.7%) responses each. The average number of hours a week was 36.3. The number of hours worked per week ranged from a minimum of 4 hours to a maximum of 80 hours. 7 participants identified working more than 40 hours a week. Fig. 10 depicts the number of participants in each of the hour brackets.

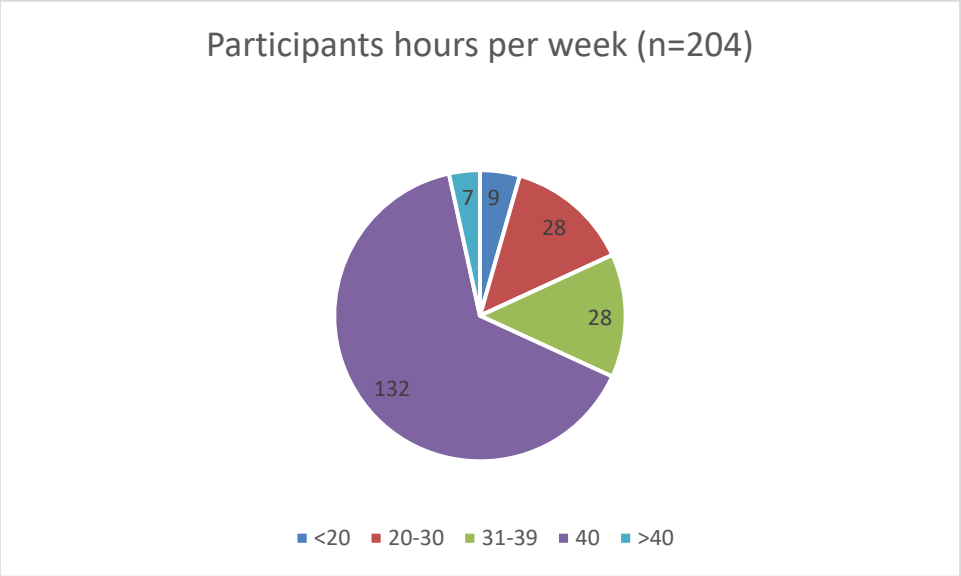

Figure 10: Hours at work per week for participants in mental health services

Pay Range

Of the 216 people who responded to the gross annual salary range (Q. 28), the majority (77.8%) earn between $40,001-80,000 a year. 91 (42.1%) participants fell in the range of 40,001-65,000, followed by 77 (35.7%) between $65.001-80,000 a year. Fig. 11 depicts the salary ranges aligned to the number of participants in that particular range. Although the question asked for per annum, gross salary, the researchers are unsure if some people who worked part time gave their income for their part time hours or gross annual salary.

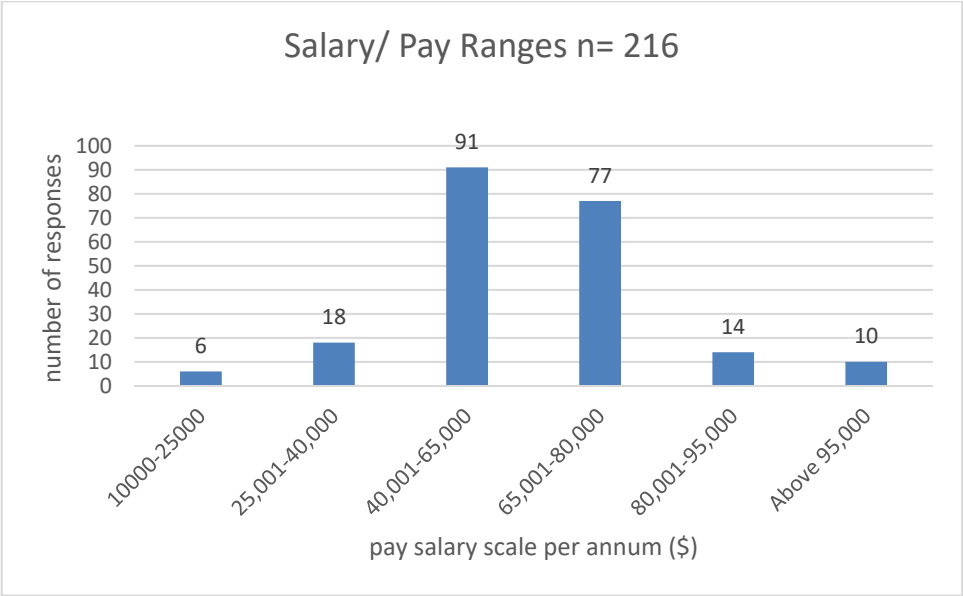

Figure 11: Pay range for participants working in mental health services

Management

Participants were also asked if their manager was an occupational therapist (Q26). In 212 responses, 25 (11.8%) people reported that they have an OT as a manager. A resounding 187 people (88.2%) do not have an OT manager. This finding alludes to questions further on in the survey and analysis that pertain to roles and the understanding of OT and management.

Summary of participant's current positions in mental health

When asked about whom the participants worked for, a resounding 76 percent worked for DHBs, with 16 percent identifying they work for an NGO. The largest percentage of participants work with adults (18-64), at 77.8 percent. In terms of where people work and with what team, 22 percent work with community continuing care teams, 21 percent in community rehabilitation and 20 percent in acute inpatient settings. 'Occupational therapist' is the most popular job title, with 59.5 percent, and 'case manager/ keyworker' and 'manager' both reporting at 8.6 percent. In terms of salary, 91 (42%) participants identified in the $40,001-65,000 bracket, followed by 65.001-80,000 at 77 (35.6%). Only 11.8 percent have an occupational therapist as their manager.

Roles

Senior/ management responsibilities

Participants were asked if they had any senior/management responsibilities (Q32). Of 221 participants who responded to the question, 78 (35.3%) reported that they have senior/ management responsibilities. For those participants answering 'No', the remaining 2 management questions were not asked through the survey system flow/ display logic.

Q33- Participants who indicated they had management/ senior responsibilities were then asked how much of their time is dedicated to senior OT duties (Q.33). Of the 78 participants who did have senior management responsibilities, 27 responded with not applicable, which we can assume indicates they were in a senior OT role but do not have dedicated hours assigned as management time. Of the remaining 51 eligible participants, 45 participants listed the hours per week allocated. The range varied from 1 hour a week to 40 hours a week. There were 2 peaks in the results, as shown in Fig. 12. 1-5 hours per week was reported for 16 participants (35.5%), with 10 participants (22.2%) at 5-10 hours and another peak of 13 participants (28.9%) identifying at 15-20 hours. The median was 10 hours a week, with the average at 11.33 hours per week allocated.

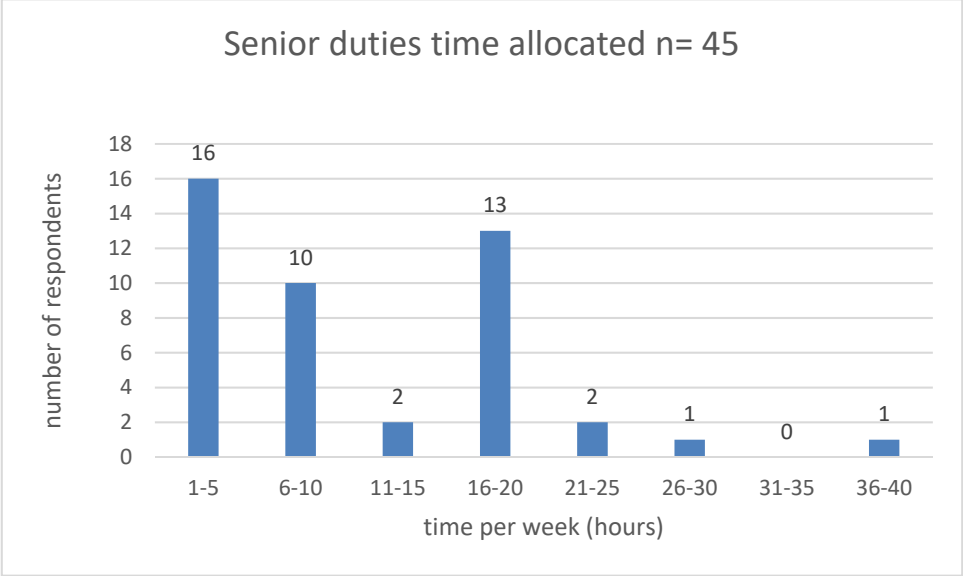

Figure 12: Allocated hours per week for senior duties

Time split manager/ clinician

Participants with senior/ management responsibilities were also asked if their position was management, clinical, or both; 72 participants responded (Q. 34). Just under half of the participants worked in a mixture of both clinical and management, at 31 (43%) participants, with 29 (40.3%) participants reporting they worked in a senior clinical role; management was identified by 12 (16.7%) participants.

Split between management and clinical

Fifty-one participants were asked to record the split between the 2 duties out of 100 percent (e.g. 80/20). Due to the various responses from the participants, the information was not usable. Some recording out of 100 percent, while some recorded a point (e.g. .2/.4) of their time, but their hours may not have been full time or their values did not add up to 1. The researcher is unable to provide an overall summary of the data.

Tasks/ Roles in undertaken in a position

Participants were asked to identify the roles/ tasks they undertook as part of their work (Q. 36). From a predetermined list, participants ranked what tasks and roles they performed and how often they performed them under the following headings: most during their day, next most frequent, then from time to time/ if required.

Regarding analysis, participants who had checked any column were added, and the most common task/ roles were recorded- frequency (see Table 6, Column A). The ranking was then inverted (see Table 6, Column B), and tasks/ roles frequency were given a ranking and recorded against each rating to enable examination and determination of the time consumption of the tasks/ roles. In terms of the tasks that participants undertook in their positions, intervention was the most common task (87%), as well as the task that ranked highest in time consumption. Participants identified documentation and administration as the second most common task completed in their work, as well as second in terms of weighting of time spent. Assessment was third for both frequency and time spent, whereas, although supervision was a task that participants undertook from time to time, case management possessed greater time consumption. Although recorded as how often, the survey identified case management as the task completed it weighted higher for consumption (time spent) than supervision.

Table 6: Tasks and Roles of Participants Working in Mental Health

n= 211	Column A (%)	Column B
Intervention	n=187 (87%)	473
Documentation and admin	n=182 (86%)	417
Assessment	n=179 (85%)	391
Supervision	n=146 (69%)	227
Case management	n=128 (61%)	295
Senior duties (OT related)	n=93 (44%)	145
Senior duties (other professions)	n=79 (37%)	140
Training/ education of staff	n=9 (4%)	9
Business management/ promotion/ community liaison	n=4 (2%)	4
Total number of responses	1007	

Key: Column A- People who use the following skills/ tasks as part of their role. Checked in either column: 1,2,3- How often/ frequency).

Column B- With weighting of task (amount of time/ time consumption) (3 given to indicate most time spent in this role, 2 the next most frequent role, 1 given to indicate only from time to time/ if required)

Summary of Roles

When asked about senior/ management responsibilities, 78 (35.3%) participants identified that they have senior or management responsibilities, with 72 participants responding whether such responsibilities were clinical and/ or management, with the most common mix as clinical and management with 31 (43%) participants. When asked about senior/ management duties, 45 participants recorded their actual time allocated to the senior/ management duties, which ranged from 1-40 hours per week.

The majority of participants reported spending most of their time undertaking intervention (87%), along with administration and documentation (86%) as parts of their roles. Assessment was also a common role, with 85% of a participant's undertaking assessment in their work. The survey allowed the researchers to analyse the total time spent in the roles/ tasks, as well as weight which tasks are completed the most, with intervention also the most common task and role undertaken.

Factors that influence retention

As noted in the literature review, satisfaction is an antecedent of retention (Freda, 1992) along with a multitude of other factors (Hayes et al., 2008; Scanlan et al., 2010; Scanlan and Still, 2013). For the purposes of analysis, satisfaction was used as a proxy of retention in a number of questions. A satisfaction rating as the dependent variable was used to determine whether there was a correlation between that, and potential retention factors.

Satisfaction

Participants rated current job satisfaction on a 1-9 Likert sliding scale (Q. 38). They were asked to rate their satisfaction with their current position, and 202 responses were given. The average satisfaction rating on a Likert scale from 1-9 was 6.25 (9 being very satisfied with their current position in mental health and 1 being very dissatisfied) with a median of 7. Table 7 shows the range of satisfaction ratings for the 202 participants. In 2013, Scanlan and Still found the job satisfaction mean to be 6.24 on a 10 point Likert scale for 34 occupational therapists working in mental health in Australia. The averages for the 2 studies were similar However, the current study had 202 responses, while Scanlan et al. (2013) had 34.

Table 7: Job Satisfaction Rating of Occupational Therapists Working in Mental Health

Rating on Likert	n=	%	
9	16	8%	Very satisfied
8	39	19%	
7	57	28%	
6	41	20%	
5	14	7%	
4	12	6%	
3	8	4%	
2	4	2%	
1	11	6%	Very dissatisfied
total:	n= 202	100%	

Due to the nature of the comparisons and establishing links with push, pull and attractions, for the remainder of data analysis and consideration, any participants who did not answer the satisfaction question had their responses for remaining questions removed. Following the cleansing of the data during the analysis, the responses from 202 people were used, as those participants responded to the satisfaction question. 8 participants had not answered the satisfaction question, and were removed because they had not responded to any subsequent questions. Another 3 participants had not responded to the satisfaction question and had only completed some of the following questions, so their data from the satisfaction question onwards was also removed.

For a number of the questions (see Appendix C for the master list of survey questions), participants were asked to indicate whether they agreed or disagreed with a list of statements about their position (using a 6 point Likert scale). For two (2) particular questions with nominal data, (Q. 39- Factors Rated According to View of Current Position and Q. 40. Attraction to the current position and applied for it because…) some statistics and layout issues had to be resolved. Following a discussion with the organisational researcher and master's supervisor, the answers given with 'strongly agree' and 'agree' were grouped together, as were 'strongly disagree' and 'disagree' together. No neutral response was provided as an option. Previous research had argued that participants might choose a neutral option to avoid thinking and having to choose between their positive and negative thoughts on a particular factor or issue (Nowlis, Kahn, & Dhar, 2008). In an article on research and the use of scales, Lozano, Garcia-Cueto, and Muniz (2008) suggested that reliability increases when there are more points on the Likert scale. Therefore, the 'somewhat agree' and 'somewhat

disagree' responses were treated as the neutral position, forming a 6 point Likert scale. A 'not applicable' option was also provided. Appendix I- Results shows the aggregation of all agree and all disagree scores together. To create a positive correlation between the factors (agreement was scored low) expected to correlate with satisfaction, the satisfaction scores were reversed in SPSS before further work was undertaken.

Retention and Attrition

Relationship between views on current role and job satisfaction

The factors listed for the question about participants' perceptions of various characteristics pertaining to their current position were taken directly from Scanlan and Still's (2013) survey (Q. 39). As previously described, the 6 point Likert scale on the current survey asked participants to rate from 'Strongly Agree' to 'Strongly Disagree' with the 'Somewhat Disagree' and 'Somewhat Agree' options acting as the neutral during analysis. Scanlan and Still (2013) used a 5 point Likert scale that included a 'Neutral' position.

Table 8: Correlation Matrix between Job Satisfaction and Perception to Current Position (Pearson Correlation r)

	Satf	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	18	19	20	21	22	23	24	25	26
Satf	1	.545*	.265	.176	0.085	.246	-.238	.430*	-.108	0.041	.483*	-.038	.279	.288	.338*	.482*	.349*	.456*	.436*	.289	.403*	.347**	.270	.393*	.360*	.335*
1		1	.393*	.337*	0.104	0.101	-.355*	.633*	0.048	.193	.396*	0.011	.204	0.102	.279	.345*	.233	.348*	.270	.229	.360*	.249	.208	.217	.270	.384*
2			1	.402*	0.114	-.058	-.175	.274	0.096	.316	.245	.171	.196	.267	.265	.249	.214	.349*	.231	.196	.284	0.116	.159	0.053	.171	.284
3				1	.349*	-.229	0.005	0.067	.346*	.460*	.233	.370*	0.139	0.101	0.120	.273	.235	.270	.151	0.103	.268	-.009	0.114	-.046	0.113	0.066
4					1	-.235	0.057	0.009	.530*	.294	0.087	.165	-.061	-.107	-.030	-.028	0.030	-.018	-.035	0.011	0.011	-.098	0.011	-.197	-.032	-.082
5						1	-.152	.225	-.419*	-.396*	0.090	-.324*	-.044	0.124	0.135	0.106	0.007	.148	.232	0.130	.192*	.290*	0.052	.475*	.328*	.237
6							1	-.433*	.169	0.079	-.276	0.096	0.016	-.078	-.180	-.263	-.143	-.296	-.216	-.090	-.144	-.177	-.234	-.183	-.217	-.191
7								1	-.121	-.022	.277	-.141	0.137	0.058	.186	.245	.228	.293	.259	.203	.232	.287	.166	.338*	.381*	.507*
8									1	.577*	-.049	.209	-.001	-.158	-.147	-.055	-.054	-.124	-.170	-.050	-.023	-.254	-.045	-.287	-.254	-.166
9										1	0.130	.423*	.149	0.100	0.095	.159	0.136	.176	0.090	0.051	.165	-.143	0.032	-.205	-.123	-.029
10											1	0.050	.188	.349*	.416*	.722*	.357*	.681*	.510*	.268	.636*	.218	.323*	0.133	.345*	0.128
11												1	0.111	.157	.205	.153	0.008	0.103	0.063	-.065	0.117	-.056	0.048	-.120	-.068	-.025
12													1	.525*	.302*	.270	.470*	.246	.203	0.088	.244*	0.101	0.120	0.076	0.010	0.113
13														1	.738*	.567*	.408*	.631*	.537*	.176	.445*	.162	.177	.194	.148	.142
14															1	.603*	.272	.637*	.570*	0.142	.463*	.293	.247	.180	.230	.214
15																1	.334*	.757*	.682*	.279	.689*	.275	.379*	.221	.369*	.249
16																	1	.407*	.284	0.135	.353*	0.079	0.128	.148	.225	.192
18																		1	.736*	.270	.686*	.213	.357*	.263	.386*	.295
19																			1	.471*	.578*	.355*	.330*	.297	.430*	.342*
20																				1	.427*	.365*	0.101	.208	.269	.212
21																					1	.265	.232	.264	.334*	.275
22																						1	.336*	.336*	.359*	.252
23																							1	.201	.149	0.097
24																								1	.468*	.381*
25																									1	.507*
26																										1

*. Correlation is significant at the 0.01 level (2-tailed). Key: Moderate positive correlation Strong positive correlation Negative moderate correlation

Table 8: Key for correlation matrix: Satf- job satisfaction, use my personal initiative or judgment (1), Multitasking (2), much concentration (3), contact time with clients is demanding (4), enough time to perform my tasks (5), Management decides what everybody has to do (6), independence and freedom in how I do the work (7), emotionally demanding (8), work very hard (9), My manager is concerned about the wellbeing of the people that work for her/ him (10), work very fast (11), good relationships with my colleagues (12), performance feedback from my manager and co-workers (13), feedback on performance via performance management system (14), my manager inspires me to do my best work (15), my colleagues are willing to give me help if I ask for it (16), achievements are recognised by my manager (18), performance is recognised and rewarded appropriately (19), Satisfied my current pay (20), my manager uses his/ her influence to help me solve problems (21), My physical working conditions are adequate (22), job is secure (23), good work/ life balance (24), flexibility in the hours (25), own decisions about how to schedule my work (26)

The correlation matrix (Table 8) was developed using SPSS. Table 8 includes the correlation between the dependent variable of satisfaction matched with the factors identified in a participant's view of their current position. The factors are ranked by the strength of correlation. According to https://explorable.com/statistical-correlation, a number (r) above 0.5 or below -0.5 shows a high correlation between factors, 0.3-0.5 shows a moderate correlation, and a negative moderate correlation (between -0.3 and -0.5). The percentages between 0.1-0.3 and -0.1 and -0.3 show weak correlation, with between -0.1 and 0.1 as none or very weak correlation. Of the 25 factors, the pull factors (highlighted in yellow on Table 9), showed that one factor had a strong correlation with satisfaction and 12 exhibited a moderate correlation with satisfaction. Three push factors (identified in green highlight on Table 9) had a small negative correlation. The factors coloured in blue in Table 9 were possessed a weak correlation or no correlation.

Using the matrix table (Table 8), the factors were correlated with job satisfaction and against other factors. Use of personal initiative and judgement with job satisfaction possessed a strong correlation of 0.545. During the analysis, some factors clustered, and patterns emerged in the results. Of note, 4 of the top 5 moderate correlations related to management (see Table 9). These statements were 'my manager is concerned about the wellbeing of the people that work for her/ him', 'my manager inspires me to do my best work', 'achievements are recognised by my manager', and 'performance is recognised and rewarded appropriately'. Concerning negative correlations, low job satisfaction was related to the following statements: 'I work very fast', 'it is emotionally demanding', and 'management decides what everybody

has to do'. Although Table 8 is used to illustrate the factors in relation to correlation with job satisfaction, the factors' correlations with each other are noteworthy. For example, factors 6 and 7 (refer to key on Table 8 or Table 9 for number in brackets beside factor) have a moderate negative correlation as shown in the matrix (Table 8). Participants who stated 'management decides what everyone has to do' did not agree with 'the position gives me considerable opportunity for independence and freedom in how I do the work'.

Table 9: Factors Rated According to View of Current Position

Q39	Satisfaction Correlation r value	Strongly Agree (1) Agree (2)	Neutral (3),(4)	Disagree (5) Strongly Disagree (6)	Total
use my personal initiative or judgment (1)	0.545*	177	20	4	201
My manager is concerned about the wellbeing of the people that work for her/ him (10)	0.483*	119	53	21	197
My manager inspires me to do my best work (15)	0.482*	81	85	27	193
achievements are recognised by my manager (18)	0.456*	99	64	29	192
performance is recognised and rewarded appropriately (19)	0.436*	58	92	44	194
independence and freedom in how I do the work (7)	0.430*	136	51	13	200
My manager uses his/ her influence to help me solve problems (21)	0.403*	88	72	30	190
good work/ life balance (24)	0.393*	114	69	13	197
flexibility in the hours (25)	0.360*	80	80	47	197
My colleagues are willing to give me help if I ask for it (16)	0.349*	152	42	2	196
My physical working conditions are adequate (22)	0.347*	74	87	39	200
feedback on performance via performance management system (14)	0.338*	78	81	35	194+7
own decisions about how to schedule my work (26)	0.335*	133	53	14	200
Satisfaction- my current pay (20)	0.289	59	83	56	192
performance feedback from my manager and co-workers (13)	0.288	102	75	17	194
good relationships with my colleagues (12)	0.279	165	30	3	198
job is secure (23)	0.270	129	54	14	197
Multitasking (2)	0.265	192	7	0	199
enough time to perform my tasks (5)	0.246	38	80	83	201
concentration (3)	0.176	176	22	2	201
My contact time with clients is demanding (4)	0.085	129	50	15	194
work very hard (9)	0.041	151	42	6	199
work very fast (11)	-0.038	80	100	18	198
emotionally demanding (8)	-0.108	144	48	8	200
Management decides what everybody has to do (6)	-0.238	33	97	66	196

Key:

IF AGREE- then PULL

IF AGREE THEN PUSH

NEITHER AS DEPENDS OF VIEW OF PERSON if this is a push or pull

Notes for Table 9: Please note that the number next to the factors in the left column, for example 'Management decides what everybody has to do (6)', denotes the question number on the Table 8. For reference to coding, refer to Appendix C, Master copy of survey questions- also for the purpose coding, excel and SPSS)

When reviewing the factors according to the largest percentage of strongly agree/agree (see Appendix I- Results of survey), the five highest ranking factors were 'the position requires me to keep track of more than one thing at a time' (97%), 'the position gives me a chance to use my personal initiative or judgement in carrying out my work' and 'my position requires a lot of concentration' (both 88%), 'I have good relationships with my colleagues' (83%), and finally, by 'my colleagues are willing to give me help if I ask for it' (78%). Statements also worth highlighting are 'my position requires me to work very hard' (75%) and 'my position is emotionally demanding' (72%). Although these factors ranked highly with 'agree' on the Likert (See Appendix I, Results of the survey), they ranked as a weak or no correlation to satisfaction in Table 9. When reviewing the survey's development (Appendix B), it was noted that some of these factors resulted from research that examined OTs and their working lives but do not add to the understanding of retention.

A relatively high number of participants disagreed with some factors. For example, 41 percent disagreed with the statement, 'I always have enough time to perform my tasks,' and nearly one third (29%) did not agree that 'I am satisfied with my current pay,' although this was only weakly correlated with job satisfaction ($r = 0.289$). Nearly a quarter (24%) disagreed with the statement, 'I have flexibility in the hours I work,' which has a moderate relationship with job satisfaction ($r = 0.36$).

Just under a half of participants disagreed with the statement, 'my performance is recognised and rewarded appropriately' (44%). The statement had a moderate correlation with job satisfaction at r .436. One fifth (20%) of participants disagreed with the statement, 'my physical working conditions- climate, noise, design or workplace and materials are adequate,' and just under a fifth (18%) disagreed with the statement, 'I get enough feedback about the quality of my performance as part of the organisation performance management system'. In contrast, just over one third (34%) of participants disagreed with the statement 'management decides what everyone has to do'. The full list of responses can be seen in Appendix I in the Survey Results.

Retention/ Pull

Current Pull

Perks/ Benefits of current position

Participants could select from a predetermined list of perks and benefits, (such as professional development, external supervision and vehicle to use) and an 'other' option with a text box (Q. 31). Of the 197 people who responded to this question, most selected more than one option; there were a total of 445 responses, including 25 'other' responses. These were coded and added to existing and expanded categories. The 25 'other' responses included perks and benefits such as gym membership, discounts on health insurance and payment of APC. Several of the 'other' comments were added to the list of categories already developed, while others were included within already established categories, such as health and medical benefits and subsided health insurance. For example, Annual Practicing Certificate was not an option given in the pre-determined list, but several participants wrote APC into 'other,' so this was added to an existing category. Of note, 15 people selected 'none of the perks above' and did not use 'other' to record any perks/ benefits.

The range and number of participants who identified with particular perks and benefits can be seen in Fig. 13. The top perks and benefits identified were continued professional development, 116 (58.9%), with phone and OTNZ-WNA membership each identified as a perk by 82 (41.6%) participants. Participants from DHBs receive an 80% reimbursement of OTNZ-WNA membership under their union (MECA) contract. 76% of participants were from DHB in the survey, so we would assume/ expect to see the perk/ benefit of OTNZ-WNA membership as a significant percentage and, if anything, it has been under reported.

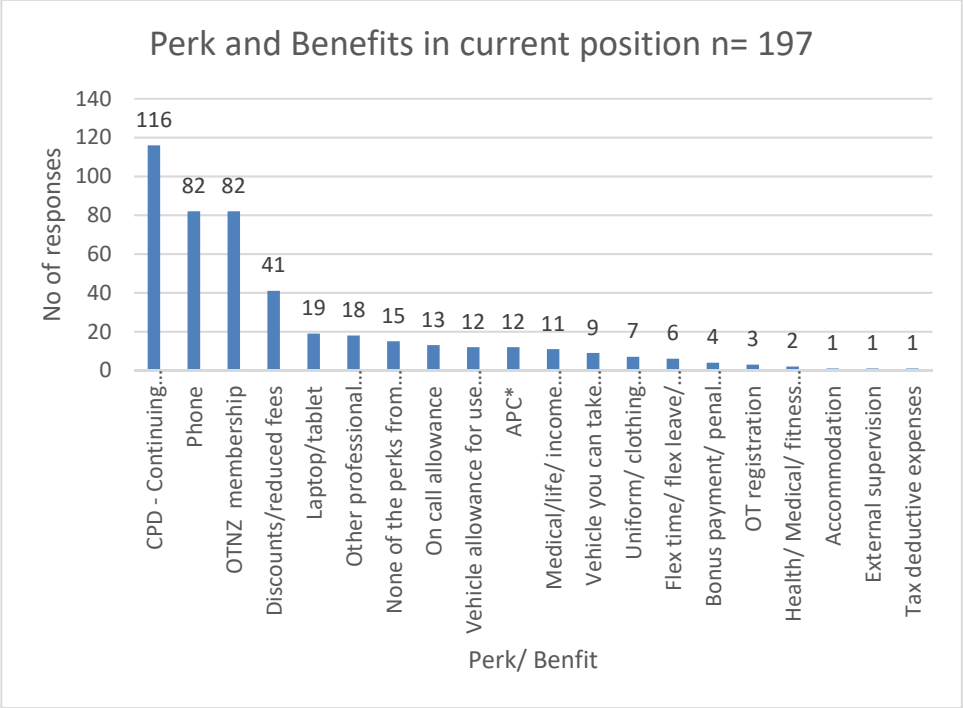

Figure 13: Perks and benefits of participants

Current Job- Rewards/ positive aspects

Participants were asked to indicate which factors/aspects, from a list of 23 items/ factors (and an 'other' text box), are the most rewarding/positive aspects of their current position (Q. 47). Participants were told they could select as many aspects as apply.

Table 10: Top 10 Responses of Most Rewarding/ Positive Aspects of Current Position

Current job- most rewarding/ positive aspects	N= 202	Rank (%)
Direct client contact	167	1 (83%)
Relationship with team and peers	124	2 (61%)
Continuing education/ Professional development	103	3 (51%)
Opportunity for professional/personal growth.	101	4 (50%)
Work/ life balance	87	5 (43%)
Nature of caseload	86	6 (42.5%)
Program development	82	7 (41%)
Flexibility of hours	75	8 (37%)
Participation in service activities	72	9 (36%)
Team opinion of occupational therapy	70	10 (33%)

There were 1449 responses from the 202 participants eligible to answer this part of the survey. Table 10 lists the top 10 responses and highlights the importance of direct client contact, nature of workload, team dynamics of occupational therapy (relationships,

supervision, team opinion of OT), professional development and personal/ professional growth activities. The Flexibility of hours was also important as a rewarding/ positive aspect. The first four factors of direct client contact, relationships with the team, opportunities for continuing education and personal and professional development and growth were identified as positive aspects of their current positions by at least half of the participants. The top 2 factors concur with Scanlan and Still's (2013) findings, which also ranked client contact and relationships with peers as a positive aspect of their positions.

Staying in a past position- past pull

Participants were asked to indicate the factors that have helped keep them in their mental health positions in the past from a list of 22 items and an 'other' text box (Q 66). Initially, only participants who had reported holding two or more mental health positions in their (Q. 14- N=159) (and who had answered 'satisfaction' and made it into cleansed data excel sheet) were to be shown this question through the Qualtrics flow logic. However, due to an error in the survey set up, this question was shown to all participants. It became evident when analysing the data that Qualtrics had erred, as 10 'other' responses reported that they had never worked in mental health before. Unfortunately, participants may have answered this question based on a previous position that was not necessarily a mental health position. Filtering was used in the data analysis. Anyone who did not answer Q. 14 (blank) or answered with a '1' response to Q. 14 was filtered out; 147 eligible participants remained.

Participants (n=147) responded to the list of options with 1108 responses. The factors that helped keep people in their mental health positions in the past were 'direct client contact' together with 'nature of caseload', another cluster was relationship with the team and peers, team opinion of OT and management style of the team. In some circumstances, depending on the type of supervision, this response was clustered with the team and management. Opportunity for professional growth, continuing education and professional development, along with program development and participation in service activities were all considered important factors for keeping participants in their positions in the past. Table 11 lists the top 10 factors. When reviewing the survey results, a pattern emerged across a number of survey questions. For example, direct client contact and the nature of the workload also featured as top 'Pull' factors in the question about a person's current position. Scanlan and Still (2013) found similar responses to these 2 areas in their survey.

Table 11: Top 10 Factors that have Kept Participants in their Positions in the Past

Factor	n = 147	Rank, %
Direct client contact/ contributing positively to client outcomes	127	1 (86.4%)
Relationship with team and peers	94	2 (64%)
Opportunity for professional growth.	81	3 (55.1%)
Nature of caseload	72	4 (49%)
Continuing education/ Professional development	72	4 (49%)
Team opinion of occupational therapy	57	6 (38.8%)
Participation in service activities	56	7 (38%)
Management style of team	55	8 (37.4%)
Program development	53	9 (36%)
Supervision	52	10 (35.4%)

Summary of retention (pull)

Direct client contact, relationships with the team, opportunities for continuing education and personal and professional development and growth were identified by at least half of participants as positive aspects of their positions. Flexibility of hours was also considered a positive aspect. Continuing education was seen as the most common benefit of a current position.

Clustering of management factors, including performance, feedback, and recognition, can be seen when correlated with job satisfaction. Using personal initiative was also important for good job satisfaction.

In terms of what has kept people in their positions in the past, direct client contact and nature of caseload feature highly. Relationship with the team and peers, team opinion of OT and management style of the team also proved important in past positions. Supervision was also rated as an important pull factor in past positions. Opportunity for professional growth, continuing education and professional development, along with program development and participation in service activities were in the top 10 factors.

Attrition/ Push

Current position- Leaving or quitting

Participants were asked to choose, from a 28 item list (Q. 48(1), the factors that that might contribute to you leaving/ quitting their current job. The 5 top factors that participants

identified were stress and overload, lack of career advancement, management style of the team, leaving for a promotion and career advancement, as well as an increase in caseload or high caseload (which may lead to stress and overload). Table 12 shows the ranking of the top 10 factors identified by participants for leaving their current position.

Table 12: Top 10 Factors that Might Contribute to Participants Leaving/ Quitting Their Current Position

Q 48 (1)	n= 154	Rank (%)
Stress/ Overload	65	1 (42.2%)
Lack of career advancement	59	2 (38.3%)
Management style of team	54	3 (35%)
Promotion/ career development	53	4 (34.4%)
Increasing/ Too high of a case load/ caseload size	49	5= (32.8%)
Excessive paperwork	49	5= (31.8%)
Generic work/ Not using OT skills	47	7 (31%)
Multiple demands	44	8= (29%)
Red tape and bureaucracy/ restructuring	44	8= (29%)
Salary	42	10 (27.3%)
Total responses	977	

Current position- Stressors and Demands

Participants were asked to identify the most stressful and demanding parts of their current job (Q. 41). They were asked to choose as many factors as applicable from a list of 22 items and an 'other' option.

Table 13: Top 10 Stressors and Demands of Occupational Therapists Current Positions in Mental Health

Stressor/ demand	N=202	Rank (%)
Role conflict/ role blurring with other professions	75	1 (37%)
Excessive paperwork	74	2 (37%)
Lack of respect or understanding about OT from other professions or team	71	3 (35%)
Multiple demands	69	4 (34%)
Stress/ Overload	66	5 (33%)
Chronicity of clients	62	6 (31%)
Increasing/ Too high of a case load/ caseload size	58	7= (29%)
Management style of team	58	7= (29%)
Generic work/ Not using OT skills	57	9 (28%)
Daily dealing with client trauma and pain	56	10 (27.5%)

Of the 202 participants who responded to the question, 976 responses were given. The top five stressors or demanding aspects of a participants current jobs were role conflict and blurring with other health professionals, excessive paperwork and lack of respect or understanding about OT from other professions or the team. Multiple demands, along with the factor of stress and overload, also ranked high. Table 13 lists the top 10 responses to the stressors and demands of the participant's current position.

Current position- Turnover intent.

Participants were asked if they were content in their current position and wished to remain in it. Of the 196 people who responded, 144 were content (yes) and wished to remain in their current position. 52 participants responded that they were not content in their current position (no) and did not wish to remain in current position.

If a participant responded yes, then they were zoned off (display and flow logic on Qualtrics) to the question about rewarding aspects of their position (Q31).

Only participants who responded no were asked to answer (zoned into/ flow logic) the following 3 questions.

For the 52 'no' responses to Q. 43, they were posed in a further 3 questions:

Table 14: Turnover Intent relating to Quitting Position and Looking for New Position.

'I often think about quitting my job':		
	n= 52	%
1 Yes	41	79%
2 no	11	21%
'As soon as I find another job I will quit':		
	n=52	%
1 Yes	32	62%
2 no	20	38%

'I am actively looking for another job

	N=52	%
1 Yes	43	83%
2 No	9	17%

Even though they were not content with their current position, 9 participants were not actively looking for another job. Of the 52 participants who initially answered no to being content

with their current position, just over half (52%) responded yes to all three questions. The response percentages can be seen in Table 14.

Current position- Push in the future

As with questions Q. 48(1), current position, and Q. 48(3), past positions, participants were asked in Q. 48(2) to indicate the most important factors to the situation described from a list of 28 factors plus an 'other' text box. Participants were asked if the factors were to change, that that would increase the likelihood wanting to leave their position in the future. Interestingly, there were double the number of responses to this question (responses were 1891) compared to reasons for leaving current position (Q. 48(1) and past reasons for leaving (Q. 48(3), which used the same list of factors in a table format for all 3 questions (see Appendix C for master list of survey questions).

Table 15: Top 10 Factors that Participants Would Consider Leaving their Current Positions in the future

Q 48(2)	N= 163	Rank (%)
Lack of respect/ team members opinions or understanding about OT- other professions	85	1 (52%)
Stress/ Overload	84	2 (51.5%)
justify OT services	83	3 (51%)
Opportunities for further Education/ Additional degree/ Professional growth	81	4 (49.7%)
Red tape and bureaucracy/ restructuring	79	5= (48.5%)
Lack of respect or understanding of the OT profession from OT team	79	5= (48.5%)
Increasing/ Too high of a case load/ caseload size	77	7= (47.2%)
Excessive paperwork	77	7= (47.2%)
Inflexible/long hours/ insufficient time	77	7= (47.2%)
Peer relationships	76	10 (46.5%)
Total responses	1891	

For changing positions in the future, the following factors rated as the top 4, all with very similar response rates (refer to Table 15 to see the responses and ratings). The top reason that would cause participants to change positions in the future and increase their likelihood of leaving was 'lack of respect or understanding about OT from other professions or team member's opinions of occupational therapy,' with a resounding 85 (52%) participants choosing this option. Stress/ overload closely followed with 84 responses, and then 'Continually having to justify OT services' with 83 responses. Ranked at number 4,

Opportunities for further Education/ Additional degree/ Professional growth had 81 responses.

Past Position- Leaving or Quitting

Participants were asked to indicate, from the same list of 28 factors used in Q. 48(1), the most important factors that have prompted them to leave positions in the past (Q. 48 (3).

As with the factors that might contribute to them leaving/ quitting their current position (Q. 48(1), 'stress and overload' (47 responses, 37%) was most often rated as the reason for leaving. The second most common factor was the 'lack of respect or understanding about OT from other professions or team members opinions of occupational therapy', which just over a third (36%) of participants reported. Table 16 shows the top 10 factors that have prompted participants to leave their positions in the past. As discussed above, this factor was also ranked number one when asking about leaving the current position if factors changed in the future. 'Management style of team' rated third highest, with 44 people- this is the same ranking as the results for a person's current position 'push'. The only personal factor that was ranked in top 4 for each of the past, future and present questions was 'Desire to move to new geographical location' which was listed as a factor by 42 people in prompting them to leave in the past.

Table 16: Top 10 Factors that have Prompted Participants to Leave Positions in the Past

	Leave in the PAST? n= 127	Rank (%)
Stress/ Overload	47	1 (37%)
Lack of respect/ team members opinions or understanding about OT- other professions	46	2 (36.2%)
Management style of team	44	3 (34.6%)
Lack of career advancement	42	4= (33%)
Role conflict/ role blurring	42	4= (33%)
Desire to move to new geographical location	42	4= (33%)
justify OT services	39	7 (30.7%)
Red tape and bureaucracy/ restructuring	36	8= (28.3%)
Birth of child	36	8= (28.3%)
Generic work/ Not using OT skills	32	10 (25.2%)
Total responses	796	

Summary of attrition from current and past positions

Participants identified that lack of respect or understanding about OT from other professions or team member's opinions of occupational therapy were top factors that contributed to participants leaving or quitting their current position. Also featured was stress and overload, with caseload size, excessive paperwork and inflexibility/ long hours, which can all cause stress and overload, ranking in the top 10. Lack of career advancement along with promotion/ career development were also featured.

In terms of leaving a current position in the future, 'lack of respect or understanding about OT from other professions or team member's opinions of occupational therapy' with 'continually having to justify OT services' were in top 5 factors. 'Stress/ overload' is an important consideration, along with 'opportunities for further education/ professional growth'.

As with current and future reasons for leaving, stress and overload was number one reason for leaving a position in the past. A lack of respect for OT, role conflict/ role blurring, generic work and management style of the team were all top 10 factors. Lifestyle choices, such as moving to new location and birth of a child, were also reported.

Attraction- Lure and Entice

Attraction away from current position- Lures and enticements

Participants were asked what, hypothetically, could attraction them away from their current position (Q. 49). Responses were selected from a pre- determined list, and participants could choose as many as applicable. Participants responded to the question with 1114 factors identified by 186 participants. The top 10 factors in luring a person away from their current position can be seen in Table 17.

Hypothetically, higher salary and promotion/ career development feature at the top of the list as the key attraction factors from participants' current positions, with more continuing education, professional development, further education and additional qualifications (essentially, upskilling oneself) also ranking highly. These factors could be considered by management who have some control over funding, training opportunities and career advancement. Also within management's control is the flexibility of hours and vacation time.

Table 17: Top 10 Factors in Luring Away from Current Position

Factor:	n= 186	Rank (%)
Higher salary	145	1 (78%)
Promotion/ career development	122	2 (65.6%)
More continuing education/ Professional development/ Further education/ additional qualifications	94	3 (50.5%)
Desire to move to new geographic location/ physical location of position	92	4 (49.5%)
Flexibility in hours	82	5 (44%)
More vacation time	63	6 (33.9%)
Workplaces reputation/ calibre of team/ workplace	57	7 (30.6%)
Management style of team	54	8 (29%)
Decrease/change in nature of caseload in new position	49	9 (26.3%)
Decrease in paperwork	45	10 (24.2%)
Total number of responses	1114	

Current Position- Attraction

The question about attraction to the participants current position and its corresponding list of factors were taken directly from the survey developed by Scanlan and Still (2013), although the Likert scale was modified to align with the other parts of the current survey for analysis purposes. This survey used a 6 point 'Strongly Agree' to 'Strongly Disagree' Likert scale (Q. 40), while Scanlan and Still (2013) used 3 options: 'not a particular attraction', 'somewhat of an attraction' and 'quite important attraction'.

Participants were again asked to identify, on a six point Likert scale (labelled identically to Q. 39), what attracted them to their current position and why they applied for it. As explained with the previous question, there was no neutral offered. Instead, the responses of somewhat agree and somewhat disagree acted as neutral during the analysis.

Table 18: Correlation Matrix between Job Satisfaction and Attraction to Current Position (PULL) (Pearson Correlation r)

	Satf	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	26	27	28
Satf.	1	.166	0.027	0.082	0.159	.304*	.406*	.264	0.144	.202	-.241	.288	0.140	.198	.172	0.082	.278	.163	.342*	.288	.314*	-.157	0.060	.254	.345*	0.210	0.043
1		1	0.092	.485*	.392*	.252	0.113	0.024	.206	.425*	-.109	.377*	.215	0.145	.340*	0.168	.377*	0.033	.197	.212	0.076	0.081	-0.007	.342*	.322*	.270	-.041
2			1	.316*	.349*	0.202	0.089	-.010	0.071	.311*	0.057	.245	0.174	0.175	0.016	0.226	0.044	0.021	0.143	.293	0.237	0.084	-0.116	0.072	0.143	-0.013	0.252
3				1	.426*	.388*	.222	0.082	.306*	.360*	-.204	.486*	.458*	.303*	.485*	0.098	.490*	0.124	.206	.281	.213	0.051	-0.070	.405*	.250	0.121	0.058
4					1	.309*	.169	0.109	.207	.536*	-.112	.447*	.337*	.246	.286	.399*	.364*	.285	.295	.324*	.350*	0.069	.194	.254	.377*	0.161	-.077
5						1	.646*	.573*	.188	.395*	-.374*	.421*	.397*	.408*	.472*	0.108	.479*	.283	0.132	.381*	.333*	-.103	0.031	.293	.223	-0.112	0.057
6							1	.720*	0.110	.311*	-.415*	.379*	.254	.356*	.435*	0.051	.439*	.299	.164	.511*	.450*	-.294	0.093	.207	.250	-0.035	-.022
7								1	0.031	.200	-.319*	.257	.224	.225	.232*	0.032	.317*	.402*	0.040	.426*	.332*	-.173	0.113	.217	0.130	-0.196	0.052
8									1	0.102	0.024	.179	.281	.244	.375*	0.060	.191	-.022	.272	.188	.341*	-.079	0.094	.299	0.040	0.074	0.078
9										1	-.239	.581*	.463*	.413*	.328*	.428*	.620*	.219	.330*	.343*	.279*	-.006	0.078	.360*	.401*	0.194	0.124
10											1	-.268	-.304*	-.241	-.144	-.151	-.257	-.197	-.014	-.324*	-.106	-.011	0.094	-0.112	-.191	-0.079	0.061
11												1	.506*	.428*	.391*	.256*	.660*	0.134	.346*	.354*	.425*	-.063	-0.043	.367*	.417*	.352*	-.058
12													1	.540*	.487*	0.166	.496*	.173	.362*	.369*	.385*	-.029	0.049	.317*	0.124	0.190	0.233
13														1	.473*	.229*	.471*	.177	.288	.381*	.445*	-.185	0.053	.258	0.149	0.222	0.112
14															1	0.130	.542*	.149	.318*	.419*	.509*	-.126	0.103	.292	.191	0.054	0.076
15																1	.354*	0.158	.247	0.168	.211	-.004	-0.080	0.056	.257	0.220	-.119
16																	1	.160	.441*	.415*	.378*	0.032	0.091	.488*	.411*	.268	-0.080
17																		1	.183	.268	.164	-.012	0.036	.152	.206	0.081	-.097
18																			1	.449*	.413*	0.002	.212	.414*	.326*	.727*	-.011
19																				1	.559*	-.087	.187	.317*	.292	.364*	0.047
20																					1	-.485*	0.117	.330*	.204	.310*	0.066
21																						1	0.057	0.131	0.062	-0.175	0.165
22																							1	.333*	0.097	0.049	.314*
23																								1	.321*	0.210	0.087
26																									1	0.229	0.027
27																										1	-.078
28																											1

*. Correlation is significant at the 0.01 level (2-tailed). Key: Moderate positive correlation strong positive correlation Negative moderate correlation

*. Correlation is significant at the 0.01 level (2-tailed). Key: Moderate positive correlation strong positive correlation Negative moderate correlation

Key: Table 18.

organisation had a good reputation (1), student placement here (2) Education and training programs, good professional development opportunities (3), I knew other people who worked here/ recommended by a friend (4), interested in the opportunities to develop skills (5), The work was interesting and challenging (6), interested in the clinical role/ nature and type of work involved in the role (7), salary was good (8), heard that the particular team was good- supportive and worked well as a team (9), applying jobs were available (10), service/ team used evidence based/ best practice methods (11), opportunity for involvement in research (12), opportunity for involvement in quality improvement (13), service offered good career opportunities (14), worked for the organization before and felt comfortable there (15), The organization/ team appeared dynamic and/ or had a strong vision (16), I was interested in working in mental health (17), opportunity for flexibility and lifestyle needs (working hours, study leave or childcare) (18), There appeared to be a lot of variety in the role (19) The role offered me more responsibility (20), The role offered me less responsibility (21), location was good (22), The resources and infrastructure available were good (23), The team had a high regard for occupational therapy (26), fitted with my childcare needs (27), same location as my partner (28).

As previously described, SPSS was used during the analysis, and the correlation levels were interpreted through https://explorable.com/statistical-correlation for Table 18. The correlation matrix (Table 18) shows a moderate correlation between satisfaction and 5 factors, with 2 factors indicating a weak negative correlation. Regarding what attracted participants to their current position, the top 5 factors correlated moderately with job satisfaction. These factors were the work was challenging and interesting, the team had a high regard for occupational therapy, opportunity for flexibility and lifestyle needs (working hours, study leave or childcare), the role offered me more responsibility and interested in the opportunities to develop skills. In terms of negative correlations, when deliberating over the factors in relation to job satisfaction, only a weak correlation was discovered with 'applying for whatever job available', and also 'The role offered me less responsibility'. As would be expected, a number of the items appear to be the same construct. Table 19 shows the correlations in order.

Table 19: Factors about why Participants were Attracted to Current Position Rating and Correlation

Q40	Satisfaction Correlation r value	Strongly Agree (1) Agree (2)	Neutral	Disagree (5) Strongly Disagree (6)	Total
The work was interesting and challenging (6)	0.406*	159	31	4	194
The team had a high regard for occupational therapy (26)	0.345*	76	70	29	175
opportunity for flexibility and lifestyle needs (working hours, study leave or childcare) (18)	0.342*	86	52	37	175
The role offered me more responsibility (20)	0.314*	106	44	28	178
interested in the opportunities to develop skills (5)	0.304*	147	35	7	189
service/ team used evidence based/ best practice methods (11)	0.288	54	79	40	173
There appeared to be a lot of variety in the role (19)	0.288	131	46	8	185
The organization/ team appeared dynamic and/ or had a strong vision (16)	0.278	78	66	28	172
interested in the clinical role/ nature and type of work involved in the role (7)	0.264	163	25	1	189
The resources and infrastructure available were good (23)	0.254	58	88	30	176
fitted with my childcare needs (27)	0.210	42	23	15	84
heard that the particular team was good- supportive and worked well as a team (9)	0.202	66	59	26	151
opportunity for involvement in quality improvement (13)	0.198	66	74	29	169
service offered good career opportunities (14)	0.172	72	80	28	180
organisation had a good reputation (1)	0.166	81	79	20	180
I was interested in working in mental health (17)	0.163	176	18	0	194
I knew other people who worked here/ recommended by a friend (4)	0.159	57	41	38	136
The salary was good (8)	0.144	48	91	45	184
opportunity for involvement in research (12)	0.140	24	40	69	133
worked for the organization before and felt comfortable there (15)	0.082	49	26	31	106
Education and training programs, good professional development opportunities (3)	0.082	51	72	51	174
The location was good (22)	0.060	129	36	18	183
same location as my partner (28)	0.043	26	13	40	79
student placement here (2)	0.027	13	8	47	68
The role offered me less responsibility (21)	-0.157	14	30	106	150
applying for whatever jobs were available (10)	-0.241	50	44	69	163

Table 20: Factors on Why Participants Attracted to Current Position, ordered according to Percentage

Q40	Strongly Agree (1) Agree (2)	Neutral	Disagree (5) Strongly Disagree (6)	Total n
I was interested in working in mental health (17)	176	18	0	194
interested in the clinical role/ nature and type of work involved in the role (7)	163	25	1	189
The work was interesting and challenging (6)	159	31	4	194
interested in the opportunities to develop skills (5)	147	35	7	189
There appeared to be a lot of variety in the role (19)	131	46	8	185
The location was good (22)	129	36	18	183
The role offered me more responsibility (20)	106	44	28	178
opportunity for flexibility and lifestyle needs (working hours, study leave or childcare) (18)	86	52	37	175
organisation had a good reputation (1)	81	79	20	180
The organization/ team appeared dynamic and/ or had a strong vision (16)	78	66	28	172
The team had a high regard for occupational therapy (26)	76	70	29	175
service offered good career opportunities (14)	72	80	28	180
heard that the particular team was good- supportive and worked well as a team (9)	66	59	26	151
opportunity for involvement in quality improvement (13)	66	74	29	169
The resources and infrastructure available were good (23)	58	88	30	176
I knew other people who worked here/ recommended by a friend (4)	57	41	38	136
service/ team used evidence based/ best practice methods (11)	54	79	40	173
Education and training programs, good professional development opportunities (3)	51	72	51	174
applying for whatever jobs were available (10)	50	44	69	163
worked for the organization before and felt comfortable there (15)	49	26	31	106
The salary was good (8)	48	91	45	184
fitted with my childcare needs (27)	42	23	15	84
same location as my partner (28)	26	13	40	79
opportunity for involvement in research (12)	24	40	69	133
The role offered me less responsibility (21)	14	30	106	150
student placement here (2)	13	8	47	68

When reviewing the factors (Table 20), according to the largest percentage of strongly agree/agree, the top statements participants agreed with were as follows:

Participants agreed that the reason they were attracted and applied to their current position was that they were interested in working in mental health (91%), with 86 percent reported 'I was interested in the clinical role/ nature of the type of work involved in the role', and 82 percent stated that 'the work was interesting and challenging. 'I was interested in the opportunities to develop skills' (skill development) was reported by 78 percent of participants, while 71 percent chose there appeared to be a lot of variety in the role.

Of note, 31 percent of participants agreed they were simply applying for whatever jobs were available (recruitment).

Scanlan and Still (2013) also found that the caseload, 'interest in mental health', 'interesting and challenging work' were top of their list along with skill development. Of interest, location (personal factor) rated at 35 percent as an important attraction (rank of 3), and in New Zealand, bearing in mind the scale had changed, 70 percent agreed this was a consideration (ranked 6 and the top personal factor).

Disagree with factors attraction to current position

In terms of participants who disagreed with statements (stated the opposite to what the statement is saying), 71 percent disagreed with being attracted to and applying for their current position because it offered less responsibility, and 42 percent of people disagreed with the statement 'I was just applying for whatever jobs were available'.

It is of concern that 32 percent of participants disagreed with the statement that they were attracted to and applied for their current position because there was opportunity for involvement in research. Hopefully, people interpreted 'research' to mean clinical research as opposed to evidence based practitioners.

Summary of attractions of current and past positions

Participants identified several attractions away from their current position, including higher salary and promotion/ career development with more continuing education, professional development, further education and additional qualifications (essentially, upskilling oneself) ranking highly. Lifestyle factors for work life balance also featured in the top 10 attraction factors, including flexibility and more vacation time.

In terms of attraction to their current position, the role being interesting and challenging, more responsibility, and opportunity for skill development correlated highly with job satisfaction,

along with the team regard for OT and lifestyle factors. Although interest in mental health did not correlate with job satisfaction, it did have the highest percentage of responses given for reasons that attracted participants to their current position.

Frames of Reference in mental health occupational therapy

Occupational Therapy Frames of reference/ models used in practice

Participants were asked which occupational therapy frames of reference, frameworks or conceptual models guided their practice*:* (check/ mark as many as apply) (Q. 51). The question was intended to illuminate the specific OT models that clinicians used. Responses were collated from 186 participants. This question was posed to participants in this survey following the review of work from Ashby and colleagues (2013), who identified issues with professional resilience, role blurring and the need to have a solid underpinning theoretical framework and clinical reasoning.

Of the 186 participants who responded to the question in some form, 176 participants responded to one or more of the 4 options given, providing 314 responses. The options were the Model of Human Occupation (MOHO) 68.9 percent, Person, Environment Occupation, (PEO) 32.3 percent, Canadian Occupational Performance and Engagement (CMOPE) 53.2 percent, Kawa model, 14 percent and 'other' with a text box .05 percent. Fig. 14 shows the graph depicting the chosen models. One person reported using the OPMA in the other text box, which is an assessment tool that comes from the Occupational Performance Model (OPM), so the researcher assumed the participant used this as their model and recorded it as 'other,' as shown in Fig. 14.

Of the 29 people who used the 'other' text box, 19 people listed an OT model from the list and then chose to use the 'other' to list a non-OT model. 8 other participants who chose 'other' either stated a non-OT model or did not record what the 'other' was in the text box. These 8 did not choose an OT model from the list of 4 options. 2 people stated that they did not use an OT specific model.

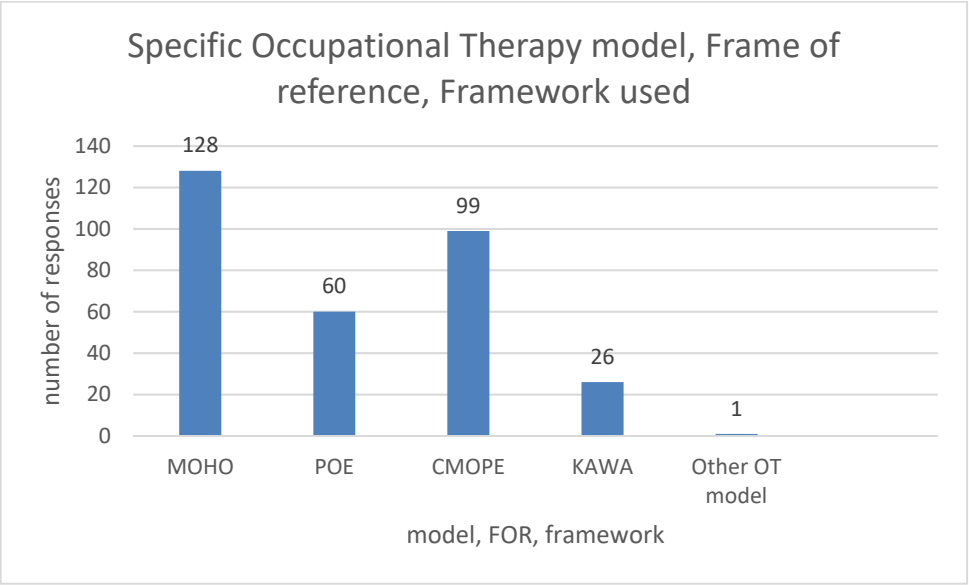

Figure 14: Specific occupational therapy model, frame of reference, frameworks used by participants

Practice models, other non-occupational therapy models or frames of reference guide that current practice

Participants were asked to list the practice models and non-OT specific models and record responses in a text box in the survey (Q. 52). As this was an open answer question, participants used a text box to type in the models, and frames of reference that guide their current practice. The responses were then listed individually in an excel list. Extensive coding was required, because although some of the responses are not frames or reference or models, they informed the models/ FOR used/ context/clinical reasoning for use.

It was decided that the answers such as 'other' in the previous question (Q. 51), that were not considered an OT model by the researchers or OT literature, would be cross referenced for replication with responses to this question. If there was not a replication between the 2 questions, then the response would be incorporated into the practice model question to ensure all non-OT models were represented.

Responses were received from 136 participants, with 414 non-OT specific models or frameworks reported as guiding respondents' current practices. 3 responses were removed as places of work, and 1 was removed because the model could not be identified, leaving 410 usable responses. The most commonly used non OT/ practice models were talk based therapies such as Cognitive Behavioural Therapy, (CBT), Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT), with 86.6 percent of participants identifying this as a frame of reference/ practice model. Ceramides and her team in the WFOT based study (2009), had responses from 7 countries about the use of CBT in occupational therapy. The study noted that CBT has become extremely popular in

interventions but OT's are aware that they respect traditional psychological domains. OTs identified using CBT principles ranged from 31.7- 91 percent in the WFOT study. Table 21 provides a full list of the grouping and categorising used.

Table 21: Non-Occupational Therapy Specific Models: Practice Models/ Frame of Reference Used to Guide Current Practice

Practice model, approach, frame of reference, delivery	n=136	Rank (%)
Talk based approaches e.g. ACT, CBT, DBT, Motivational interviewing, Psychodynamic, Psychoanalytical, Psychoeducation	118	1 (86.8%)
Recovery/ consumer lead recovery	50	2 (36.8%)
Policies, protocols, broader health outlook (based on some general guidelines in health), team set up e.g. IDT, particular way of working/ approach of team, part of OT problem solving process or way of viewing, monitoring and evaluating treatment/ function/ progress, community outlook	39	3 (28.7%)
Strengths/ humanistic	33	4 (24.3%)
Cultural models e.g. Te Whare tapa Wha, Fonofale, Pounamu	32	5 (23.5%)
Developmental, neuro based, psychological, behavioural	21	6 (15.4%)
Mindfulness/ problem solving/ mentalization/group work- models and frameworks leading to interventions to enable people	19	7 (14%)
Words used to describe: evidence based, best practice, client centred, TUS, Outcomes focused, Research based, own values and beliefs	17	8 (12.5%)
Sensory processing/ modulation/ integration	16	9 (11.8%)
Biopsychosocial, social, psychosocial	15	10 (11%)
Boston rehab, psych rehab/ rehab model	10	11= (7.4%)
Biomedical, compensatory, adaptive, rehab	10	11= (7.4%)
Educational approaches, teaching/ learning, coaching, development theories	8	13= (5.9%)
Supervision/ leadership/ management/ business	8	13= (5.9%)
Cognitive (cognitive disabilities, Allen's) models	8	13= (5.9%)
Family models	6	16 (4.4%)
Total number of responses	410	

Surprisingly, ‘recovery’ was not identified more frequently by participants, as it is a key underpinning philosophy of mental health practice in New Zealand (Mental Health Commission, 2001). One could assume that recovery philosophy and principles are such an integral part of working in mental health that participants did not consider them a model or frame of reference by OTs, but rather an everyday way of working with clients.

CHAPTER 5: DISCUSSION

Introduction

This research aimed to explore the factors that A/NZ OTs working in mental health identify as influencing retention. In this chapter, the reported findings will be discussed with a focus on returning to the 3 research questions. The diagram about the see-saw dynamics of the concepts of push, pull and attraction (Fig. 1) will also be examined in relation to a person's current, past and present positions. The data collected and reported in Chapter 4 will be used to interrogate the model and suggest any modifications that may be warranted.

The discussion will also return to the literature to examine and compare the interactions of factors and their influence on push, pull and attraction concepts to evaluate if in fact there is a connection between the retention proxy - job satisfaction and these factors. Because this is a New Zealand based study, this thesis will also discuss the implications of the concepts of push, pull and attraction in the A/NZ context.

Finally, the strengths and limitations of this study and recommendations for further research will be discussed. The current survey provided a rich range of information relevant to the New Zealand context in both present and past positions and what participants consider when looking for a future position. The discussion will now revisit each of the research questions to examine the findings from the current study.

Retention: The 'Pull' to stay in a current position and past positions. Why stay?

Research Question 1:

What are the factors that A/NZ OTs in mental health identify as influencing retention?

1a. What are the factors A/NZ OTs in mental health identify as influencing retention (job satisfaction) in their current position?

1b. What are the factors A/NZ OTs in mental health identify as influencing retention in past positions?

This study demonstrated a wide range of factors people value as important for remaining in their positions, both current and past. The discussion will now consider the factors, and the themes, that influence retention and compare this study's findings with others.

Stay in Current position

Participants in the study responded to three questions that related to pull factors in their current positions. There were several key factor themes (clustering) that ran throughout the findings and were deemed more important than others.

Autonomy

The most important pull factor participants identified, the only factor with a strong correlation with satisfaction, was the use of personal initiative or judgment. In addition, a cluster of moderately correlated factors based on autonomy (flexibility in work hours, use of personal judgement, freedom and independence in how I do my work, make own decision about how I schedule my work) also correlated with satisfaction.

Hayes et al. (2008) found that autonomy (including flexibility) was rated by 36.2 percent of participants as a positive aspect. The cluster of factors in this study differed in language from that used by Scanlan et al. (2010) and Scanlan and Still (2013), however, the importance of autonomy within work practice was also highlighted in these 3 Australian studies.

Conversely, in this study, a negative correlation between 'management decides what everyone was to do' (not allowing autonomy) and job satisfaction was seen, confirming the importance of autonomy and suggesting an important role for management in issues relating to autonomy, flexibility and staying in positions. Lloyd et al. (2003) did comment that occupational therapists have greater autonomy overall with the changing systems and organisation of health services in New Zealand

Management

There was moderate correlation between some factors relating to management and job satisfaction. The factors included manager being concerned about the wellbeing of the people that work for her/ him; feedback on performance via performance management system; manager inspires people to do their best work; performance is recognised and rewarded appropriately; and managers use their influence to help people solve problems. These factors are directly impacted on by managers, so an awareness that these can be factors that influence retention are important.

Rewards and wellbeing

Scanlan and Still (2010) also found that feedback and rewards had a moderate to strong correlation with job satisfaction (.44 and .5 respectively), in line with correlations of this study (0.338- 0.436). This agreement may imply that mental health OTs in New Zealand, like

in Australia, would benefit from feedback, rewards and recognition from management (if this not already in place) to be satisfied in their position.

Reviewing, investigating and implementing feedback, performance reviews and recognition or achievement systems for occupational therapists may be a useful tool in enhancing job satisfaction (Moore et al., 2006) and thus retention. Although this study did ask participants about the perks and benefits of their current position, we need to further investigate what reward and recognition system A/NZ OTs might find meaningful by asking participants specifically.

The full relationship between the impact of management and job satisfaction has not been fully investigated in its own entity in occupational therapy or in specific mental health literature reviewed from 2000 onwards. Although, according to Siegriest (2002), people who believe that their efforts are not rewarded (pay and other rewards, non-tangible such as recognition and accolades) are more likely to have lower levels of wellbeing at work. The longer an OT had been in a position, the higher their acknowledgement of the value of rewards and recognition.

Scanlan, et al. (2013), in an Australian study about mental health OTs wellbeing at work and turnover intent found a strong correlation between job satisfaction and reward- recognition and prestige. Similarly, in a 1993 study by Sweeney, Nicols, and Kline (1993), rewards and recognition were discussed as a key dimension to reducing stress and burnout (which can lead to attrition).

Salary can be viewed as an element of recognition. In this study, there was a weak correlation between satisfaction with current pay and job satisfaction at r= 0.289. Just over a quarter of the participants agreed that they were satisfied with their current pay (as discussed in the section about attractions, salary is a key attraction for OTs looking at new positions).

Work/ Life balance and wellbeing

Work-life balance is a subjective view that the mix between work and non-work activities is satisfactory (Brough, Holt, Bauld, Biggs, & Ryan, 2008). Work-life balance and satisfaction influences wellbeing (Scanlan, et al., 2013). In this study, the factor of good work/ life balance had a moderate correlation with job satisfaction. Management needs to consider how wellbeing for OTs can be positively influenced by their position demands, as when a person identified wellbeing at work, they reported lower turnover intent (increased likelihood of staying in a position) (Scanlan et al., 2013). Part of wellbeing relates to decreasing stress and overload in a position. A 2003 study based on New Zealand occupational therapists in

Mental Health services, showed a moderate correlation between stress levels and those OTs wanting to change jobs (Lloyd et al., 2003).

Occupational therapists need to develop good coping/ self-care strategies to ensure their wellbeing while working in mental health. Ashby et al. (2013) discuss the importance of the concepts of professional resilience through professional self-care and maintaining a strong sense of professional identity (discussed below).

Relationships with team

In this study, the most rewarding parts of a person's current position that also concurred with the findings of Scanlan et al. (2013) and Hayes el al. (2008) pertained to the importance of the relationships with a team incorporated social/ emotional work environment (relating to team). The results in this study show that the factors of 'colleagues willing to help out' and 'good relationships with colleagues' ranked highly on the list in relation to staying in a person's current position.

These findings reiterate Hayes et al. (2008) statement that there is a need to further examine the promotion of positive social and emotional work environments to attract and retain occupational therapists. Relationships with the team and peers was also identified as a rewarding/ positive aspect of the current position, along with the team's opinion of OT. In a British study by Richards (1998), staff relations were also identified as an aspect of why OTs stay in their positions. Historically, OTs have been concerned about the team's view of occupational therapy and their roles, skills and contributions. For example, in an interprofessional study Norman and Peck (1999) emphasised the need for OTs to articulate what they do so other team members are aware of their scope of practice. We will return to professional identity later on in the discussion.

Continuing education and professional development

Professional development (PD) and continuing education (CE) were both identified as a positive aspect of a person's current position and the number one perk/ benefit in a person's current position. Notably, therapists in Hayes et al. (2008) did not report this factor as a significant positive aspect within their study, as PD may have been taken as a given and part of the job. However elsewhere in the literature, evidence of the importance of PD (Lloyd et al, 2002) in an Australian study and staff development (Richards, 1998) as discussed in a British study, has been provided.

During this study, we were unable to ascertain the types of training that were positive, but as with the nature of position with case management and skills needed, an investigation of the

types of trainings that therapists find useful would constitute an excellent premise for future studies. Richards (1998) used her survey findings to develop a retention strategy to improve development opportunities with an increase in OT specific trainings being offered. She hoped this would enable staff to consolidate their skills and lead to an increase in confidence and competency.

The knowledge that PD plays some role in both a positive aspect of the position and a reward/ perk in the current study for A/NZ mental health OTs suggests management needs to ensure staff have access and monetary resources to continue to upskill. Unlike in the USA, where OTs are expected to earn a specific number of hours of Professional Development Units (PDU) to maintain registration (National Board for Certification in Occupational Therapy, 2017), New Zealand does not stipulate a required number of hours of training. However, to renew an APC, OTs must complete a reflective e- portfolio against competencies that requires professional development but not necessarily formalised trainings.

Knowing the importance of PD allows managers to forward plan for funding and development of needed trainings, as participants identified opportunities for professional growth as a positive aspect that may have a bearing on their satisfaction and thus retention. At the end of the survey, participants were given an opportunity to provide any further comments. At least 40 participants discussed either being offered a training but no paid time off to go, or paid time off to go but no reimbursement for training costs.

Nature of work

Also identified in the current study, nature of caseload and direct client contact are seen as rewarding and positive aspects of the current position. Scanlan et al (2010) and Richards (1998) also listed nature of work as one of the influential factors for staying in a position. 66.5 percent of participants agreed that their contact time with clients was demanding, a trend that did not correlate with job satisfaction. So, although participants want more responsibility, as identified as in their attraction to their current job (moderate correlation with job satisfaction), this does not necessarily mean OTs desire or want less client contact. Management can look at ways to give opportunities to staff more responsibility that involves the nature of the work they enjoy while retaining direct client contact.

Why did OTs stay in past positions?

As discussed previously, the nature of the work (clients OTs work with, setting) has been identified in both the current study and Scanlan et al. (2010) as an important reason why people have stayed in their positions in the past. Previously mentioned as a pull in current

positions, relationships with peers/ team and opportunities and professional growth have also proven important factors in keeping people in past positions, much as in Scanlan et al. (2013). Similar findings between the majority of the factors have kept participants (pull) in their current positions and in past positions. The exception was work/ life balance (which included lifestyle reasons in the clustering), which was in the top 10 factors for staying in present positions, but not in past positions. We need to understand the reasons why participants stayed in past positions, as these may be important factors in keeping them in their current position too.

Attrition: The 'Push' to leave a current position and past positions. Why leave?

Research Question 2:

What are the factors A/NZ OTs identify as influencing attrition?

2a. What are the factors that A/NZ OT's identify as influencing attrition in current positions?

2b. What are the factors that A/NZ OT's identify as influencing attrition in past positions?

This study highlighted some key findings in relation to why OTs choose to leave positions. The study looked at why people left past positions, why they want to leave their current position, and what factors would need to change in their current position to make them decide to leave in the future. The discussion will now consider some of these factors and compare to other studies.

Attrition from current position.

Some key factors were highlighted during the study as having an impact on participants leaving or thinking of leaving their current position.

Shields and Ward (2001), in a nursing study in the U.K., and Scanlan et al. (2013) both discuss the association between high job satisfaction and low turnover intent, so we need to take note of the factors and job satisfaction, particularly those that make people think of leaving their positions. This current study was unable to establish a link between turnover intent and job satisfaction. 52 participants identified that they were not content in their current positions, however, only half of these participants were actively looking for another position and indicated they would quit as soon as they found another job.

Current Job problems

The factors related to job problems were ranked in the top 10 factors for leaving a participant's current position. Those factors clustered into 'job problems' include the factors of stress/ work overload, high caseload, excessive paperwork, and multiple demands. Current job problems might also include lack of career advancement and desire for a promotion or career advancement. The factors relating to job problems were nominated by at least a quarter of all participants (29- 42%).

In Scanlan et al. (2010), the same question about important factors that might contribute to leaving a current position was asked. The results showed that 'if a job problem develops' (which includes the above issues- stress/ work overload, excessive paperwork and multiple demands) rated at 32%. Workload did not show significant results in their study, while it did in this study. Hayes et al. (2008) also found that the current job problems if not resolved category also had a high percentage at 42.6% for participants' reasons for leaving their current position. These issues related to the current job problems category should be considered by management as they review retention strategies.

The generic versus discipline specific nature of work

As previously discussed in the literature review, occupational therapists often voice concern about the generic versus discipline specific nature of work in mental health services. Hayes et al. (2008) further delved into this area in their Australian study. As with Hayes et al. (2008), in the current study, the majority of participants worked in positions requiring at least 50 percent of their work in a generic role (see Fig. 9). The generic nature of the work or not using OT skills (37%) was of concern of the current study. The theme followed through in 4 questions related to attrition, those being when OTs were considering leaving their past position (25%), leaving their current position (31%), leaving their current position in the future (40%), and when identified as a stressor in their current position (28%). Although percentages were not as high in this study as in Hayes et al. (2008), their findings showed that nearly half of participants identified insufficient use of OT skills/ generic nature of work as an issue. As shown in the literature review, generic way of work can lead to role blurring and role conflict within the team. We will now move on to a discussion of role blurring.

Professional identity and role blurring

Along with generic work, role blurring (Lloyd et al., 2004) may impact attrition from a participant's current position. In this study, 23 percent of participants identified role blurring as an issue. Evidence (Peck & Norman, 1999, Ceramides, 2010; Lloyd et al., 2004) shows

that generic way of working and in turn role blurring, with all professions in a team undertaking similar tasks in a generic model of care, can lead to a lack of respect for OTs and team members opinions or understanding about OTs and their role (for the current position, 27% in this study). Other disciplines in a team might need some education about the role of the occupational therapist and in turn, occupational therapists must learn to better articulate their role to their peers.

Role blurring was also identified as a factor in leaving the current position now and in the future; it was identified as the number one stressor in a person's current position by 37 percent of respondents. To combat role blurring, OTs need to be able to articulate their interventions with an occupational focus, as sometimes other disciplines do not understand the complexity of goals and interventions (Ashby et al, 2013). Scanlan et al. (2010) use the term role dysphoria to describe the lack of professional identity and issues with role blurring or being a part of occupational therapy. Occupational therapists need to maintain a strong professional identity to avoid role dysphoria, with ensuring meaningful occupation remains at the core of their work to perpetuate professional resilience as discussed in-depth in Ashby and colleagues (2013) study.

Only 11.8 percent of participants identified that their manager was an occupational therapist, which unto itself draws together some salient points for OTs. Occupational therapists need to be able to articulate their role and need to ensure that management is aware of scope of occupational therapy practice. This certainly reinforces professional resilience's importance, a concept discussed by Ashby et al, (2013), especially when working in a generic role in an environment that may have job problems and a manager unaware of your role.

<u>Attrition from past position</u>

Scanlan et al. (2010) identified that a desire for different type of work was a key reason for leaving positions. Although the factor is not the same, in a similar vein of wanting a change or growth, this study showed that 33 percent of people said that lack of career advancement was a reason for leaving. Lifestyle reasons did feature in the current survey, with a desire to move to a new geographical location (33%) or the birth of a child (28%). Similarly, Scanlan et al. (2010) showed that lifestyle reasons constituted one of the factors for leaving a past position.

Understanding OT

As previously discussed with attrition from current positions, lack of respect and understanding of OT was also an issue for respondents in past positions. The need for

increased professional identity to decrease role blurring and respond to a lack of understanding of the occupational therapy role in the team is imperative for staying in a position. The factors of role blurring and lack of understanding in both past, present and future positions emphasise the importance of ensuring professional resilience (Ashby et al., 2013).

Career pathways

The need for good career pathways for OTs was also highlighted in the reported lack of career advancement (34%) and opportunities for professional growth (26%) in past reasons for leaving positions. Scanlan et al. (2010) showed a high rating for these factors. Richards (1998) also found that a lack of career development was the most popular reason for leaving a position. Management must consider how they look at career pathways for staff. Although Ceramidas et al. (2009) highlight that occupational therapy is seen as an expanding and growing area, this growth does not necessarily equate to career pathways for mental health OTs. Ashby et al. (2013) discuss OTs changing jobs as a way to maintain professional resilience, but management may want to consider how to keep senior staff in their service so the skills and levels of experience can be utilised by the service itself.

Attraction/ Enticement: The 'Attraction' away from a current position and past positions.

Research Question 3:

What are the factors that A/NZ OT's identify as influencing attraction into positions?

> 3a. What are the factors that A/NZ OT's identify as influencing attraction into current position?
>
> 3b. What are the factors that A/NZ OT's identify as influencing attraction from a current position?

This study highlighted some key findings in relation to the factors that attract or entice an OT to move on from past and current positions. The study looked at why people are attracted or enticed to new positions, from their past positions and what could attraction them into new positions. The discussion will now consider some of these factors and compare to other studies.

Attraction from an OT's current position.

Salary

Management needs to be aware that a key attraction from a person's current position to a future position is, in fact, higher salary, with 78 percent of participants selecting this factor. This concurs with Scanlan and Still's (2013) findings that salary was a key attraction to a position. However, only 4.3 percent of Hayes et al. (2008) participants said they would change employment for a higher income.

Promotion/ career development

Promotion and career development is also an important consideration, with 66 percent of participants identifying this as an attraction from their current position. Scanlan et al. (2010) discussed that 67.6 percent of participants in their study identified an interest in management positions but no interest in positions without a clinical workload (which aligns with this study's finding that direct client contact is the number one positive aspect of the position). Desire for career development or promotion could be related to a key reason for leaving presented in the Scanlan et al. (2010) study: boredom or being stale.

PD/CE

The importance of continuing education and professional development is also noted in our study, with over half of the respondents identifying these factors as an attraction. This could mean more PD, CE or the quality or time/ course fees paid. This study did not ask the nature of the PD/CE that participants sought, although as previously discussed, the open comments allowed for some to voice concerns over both time and cost involved. As discussed in the literature review, professional development was anecdotally identified as an issue with the researcher colleagues.

It is difficult to assert that PD, as a factor in its own entity, had an impact on retention (Hunter & Nicol, 2002), however, this study backs up the call for continuing professional development as a retention strategy. As professional development/skill development is also a positive aspect of current and previous positions, management should consider when this factor when planning and budgeting for OTs. Participants also labelled flexibility, decreased paperwork and more leave as factors that will attract them away from their current position. The attraction away can also be seen as a recruitment strategy for management looking for staff.

Attraction into this position from a previous OT's position

Caseload and skill development

Participants were asked about what attracted them to their current position. As with the Australian studies of Scanlan et al. (2010) and Scanlan and Still (2013), the current study identified that interesting caseload (when working in mental health) and challenging work rated highly and was also moderately correlated with job satisfaction. Skill development for all 3 studies rated highly as an attraction to participants' current positions. OTs are interested in positions that offer skill development opportunities and interesting, challenging work, however, further investigation is required to identify the skill development that participants think is important.

Job availability

Scanlan and Still (2013) present a valid point about people who reported that salary and job availability may not sustain wellbeing over the longer term and may not be sufficient to remain in a position. People moving into new positions need to derive some meaning from their positions to sustain job satisfaction (Scanlan & Still 2013). It would be interesting to analyse the factors of those participants who have held multiple positions in a relatively short period of time to see if there were trends or pattern with the factors in relation to the push, pull and attraction concepts.

Location

Interestingly, location, as an attraction to the current position, rated highly in both the current study and in Scanlan and Still (2013); however, this may not be a management issue, however, with knowing of the benefits and perks, and what attracts people into a position, the location could be part of the multiple factors considered by OT's. Management needs to consider how they can use the perks and benefits part of recruitment and for advertising.

Through the discussion of push, pull and attraction concepts in past, present and future positions, it is relevant to note that there is clustering of factors into categories and themes and often the factors in the same theme correlate or rank similarly.

Push and Pull Diagram

The discussion will now consider Fig. 1, the multiple factors involved in the see-saw/ balance of staying or leaving a position, using the push, pull and attract concepts.

The findings of the study have identified some key factors that would fit with the concepts of the diagram in the A/NZ context. Those factors that fit into push, pull and attract concepts of

the diagram may vary depending on the context of the setting, but some key factors were identified in the studies that show common factors. The dynamic part of the diagram is reflected in the width of the arrows, which illustrates the weighting or importance of the factors that can swing the 'balance' and influence whether a person stay in light of current pushes, pulls or attractions.

The study's literature review discussed the Scanlan et al. (2010) model. Scanlan is of the thought that the diagram can stay the same but the factors will influence the push and pull balance (Justin N. Scanlan, personal communication, May 10, 2015). Through the adaptation and simplification of their model, for the purpose of this exploratory study, the notion of factors influencing the up and down (see saw) dynamic seems to be true. The adapted model has been used to show the factors for each of the push, pull and attraction concepts. The weighting and ranking can be used to show the importance of the factor on the balance of the continuum. In future research, it would be good to explore the professional and personal aspects of the push and pull in-depth to add to the current evidence.

General discussion of the study

During the analysis and comparisons/ relating back to the literature, intertwined and interlinked nature of the factors acting as antecedents to the concepts of push, pull and attraction has become apparent. The relationship between factors and the way they clustered was reflected in the correlations and showed which factors are important in the retention of staff in mental health services.

Management needs to be aware of the differing issues important to OTs working in mental health and how services can provide support to address staff retention. Working on roles in a team, especially with other health professionals in a generic role that facilitates role blurring, has been highlighted as a factor.

To ensure OTs continue to work in mental health, occupational therapists need to improve their professional resilience. They need to maintain or develop coping strategies and learn to articulate the relevance, use, and benefits of occupational therapy to clients in a mental health setting (Ashby et al., 2013). Priority must be given to advocating for professional development and growth to ensure that OTs receive discipline specific training and generic skills training in changing healthcare models of practice.

The need for OTs to progress in management and promotion has been highlighted, and although this would mean OTs would move positions, their skills and knowledge would remain in mental health services. As evidenced by Scanlan et al. (2010), OTs want to move

into management, and they need to promote themselves and those skills that would ensure they are good managers. OTs possess the communication and organisational skills as part of their problem-solving process to manage a team. OTs can influence strategies, policies and play a prominent part in wider health discussions.

Management needs to be aware of the differing issues in for OTs working in mental health and how services can provide support to address retention of staff. Working on roles in a team especially with other health professionals in a generic role, professional identity and role blurring has been highlighted as a factor.

To ensure OTs remain working in mental health, occupational therapists need to continue to work on their professional resilience. Occupational therapists need to maintain or develop coping strategies and be able to articulate the relevance, use of and benefits of occupational therapy to clients in a mental health setting. (Ashby et al., 2013). Priority needs to be given to advocating for professional development and growth, to ensure that OTs receive discipline specific training and generic skills training in the changing healthcare models of practice.

Professional identity is important aspect of working in differing roles in teams. The role blurring theme was identified as an issue in the results. Ashby and colleagues (2013) have identified that OTs need to ensure they use a theoretical framework in their practice to increase professional resilience. An occupational therapy frame of reference ensures that OTs keep an occupational focus and at the core of their work despite working in a discipline specific or generic role. A number of participants identified a practice model as opposed to an OT frame of reference during the study. OTs working in mental health need to review their frames of reference in order to be able to articulate their scope of practice to other professionals. Without this, there may be cause for concern in regards to role blurring. Supervisors can include models of practice or case presentation using OT frames of reference as part supervision with OTs. The researchers say this statement bearing in mind that most managers are not OTs, however; most OTs are supervised by another OT as part of their competency development.

There are implications for workforce development through reviewing the results of the study. With the increase in attention on mental health services in New Zealand (Elliott, 2017), this research comes at a time when staff are part of a review of services which can have an impact on their work and increased pressure at work. However, with the outcomes of the factors that occupational therapists have identified in this study, management and the OT's themselves now have an increased awareness of the themes that OTs have identified as the push, pull and

attraction factors. Strategies can be developed to ensure that staff are given the support to cope with the increased pressure from the increases in client numbers accessing services.

Along with this, the increases in funding as a results of reports and reviews stands occupational therapists in a good place to advocate for more OTs with knowing the benefits of meaningful occupation on a person's health. Occupational therapists have identified that a lack of physical resources has been an issue so increases in funding means that OTs can also advocate for increases in finances for resources. Occupational therapists want professional growth and so OT's can influence policy and ways of working by moving into management or senior positions. With support and supervision, this would mean that OTs can have a louder 'voice' in policy making and service delivery.

Strengths and Limitations of the study

The greatest strength of the study was the sample size and coverage of New Zealand occupational therapists working in mental health. With an approximate 68 percent return rate, the data and results significantly occupational therapists working in mental health in New Zealand. The return rate highlighted the relevance of the topic for OTs, as well as the topical nature of retention and attrition in mental health services.

This study collected its data using an online survey, a choice which may have created a barrier for OTs in shared spaces or those without access to a computer or a reliable Wi-Fi connection. Piloting showed that the survey took 15 minutes, however, if a person answered all the questions and commented in the text boxes, it could may have taken longer, and as a result, some people may not have reached the end. When reviewing Table 1, 234 people were eligible to complete the survey, however, when the responses for the questions further on into the survey were compiled, the number of participants was between 190- 200.

As previously mentioned, there were some limitations in the use of the survey results during analysis. The use of SPSS and Pearson's correlations shows a correlation between factors, however, the researchers recognise that causation cannot be assumed from, and caution must be taken when considering correlative relationships, because they do not explain cause and effect. Also, the cross-sectional design prevents us from making any causal relationship conclusions.

One limitation of the current survey was that not all participants worked clinically. Some participants only worked in management of mental health services. This limitation could have been rectified if the inclusion criteria included that the participant needed to work

clinically. This could have had an impact on the ranking of factors, but because only 12 (5%) of the participants identified as management only, it was decided to include all data.

Another limitation was that the survey did not explicitly state that people needed to hold an APC. Although this was few in numbers, it meant that the comparisons to the OTBNZ data were based on those that held APC, but as discussed previously, 3- 12 participants potentially had no APC, so this would not skew data dramatically. The researchers decided to keep these people in the survey as they were using their OT skills in mental health services in New Zealand, although this finding does highlight the need to ensure all staff have an APC. Mental health services in New Zealand may have a different context compared to other countries, and replication of the survey is encouraged, having already adapted it in part from the Australian work of Hayes et al. (2008), Scanlan et al. (2010) and Scanlan and Still, (2013). A comparison of this study to replicates in other WFOT countries would prove fruitful.

Further research needed

As previously mentioned, this survey collected a large amount of data. During the analysis, some possibilities for further research were noted. Further work must be completed with this data. For example, there may be a link between the number of years in the profession and job satisfaction and retention, a link which has been discussed in the literature but not analysed for the purpose of this study. Due to the amount and degree of depth of data collected, further associations and correlations that have not been addressed should be considered in future studies or analyses of the research data.

The research questions were based on the pull, push, and attraction concepts about OT's staying or leaving positions. We know that there are multiple factors that play into the decision making of choosing to stay or leave. However, it would be of interest to conduct further research and analysis on any particular combinations of the push, pull and attraction factors in retention and job satisfaction.

Ashby el al. (2013) discuss that OTs have strategies for dealing with challenges in their work as the work itself was satisfying. As part of this study, participants had the option to be a part of further research, so investigating the strategies that OTs employ to cope with the stressors and demands to stay in their positions would be of interest.

This study considered occupational therapists specifically working in mental health in New Zealand. The majority of the literature was based on mental health research with the assumption that working in mental health presents unique challenges. Generalise to

other OT fields needs to be undertaken with caution. The research showed some correlations and factors that relate to this specific group of people, however, further research is needed to understand if similar or different factors apply to occupational therapists working in different practice areas or other mental health professionals. The question that could be raised is, do other OT's have similar issues with role blurring in their fields of practice? Bailey's (1990) work looking at OT's in any practice area who had already left positions was instrumental in developing the survey looking at why people left positions in the past and some of which were similar to this survey.

In this study, personal and professional factors for OTs were not separated, so it would be worthwhile to investigate the professional and personal factors that influence the decisions OTs make about their work, as there is a trend towards wellbeing at work, and a work-life balance.

Conclusion

This study set out to identify the factors considered by occupational therapists working in mental health in Aotearoa New Zealand when deciding to stay/ remain or leave their current, past, and future positions.

Occupational therapists hold a valuable role within a person's recovery in mental health services in A/ NZ. Although it is difficult to ascertain the number of OTs leaving mental health services, there is concern about the percentage of OTs in mental health in New Zealand. Clients benefit greatly from the use of occupation to improve health and wellbeing, and without OTs, this area may be overlooked in a strongly medical-based health system.

With research questions based around past, current and future positions, the study looked at the concepts of push, pull and attraction in relation to factors affecting an OT's decision to stay (retention) or leave (attrition) a position. Although we could not make causative relationships due to the nature of the methodology, we identified some correlations between job satisfaction as a proxy for retention and different factors. In considering the themes and factors, our findings build upon previous research, including the Australian work of Scanlan et al. (2010), Scanlan and Still (2013), and Hayes et al. (2008). As found in previous research, retention and job satisfaction are made up of multiple factors.

This research has demonstrated correlations between job satisfaction, perception of a current position, and attraction to a position. Factors cluster around the nature of work, role blurring, team dynamics, management influences, ongoing professional growth and development all rate highly within the dynamic of push, pull or attraction into and out of positions.

To improve retention of occupational therapists in mental health, the issues must be understood at an occupational therapist and management/ service level. By developing some retention strategies, we can proactively prepare for the rise in demand for mental health services across the person's lifespan.

I recommend management consider reviewing recognition, rewards and performance system reviews along with time and/ or funding for professional development training. For OTs, this study serves as a reminder to continue to work on professional scope of practice and articulating the role of the OT in teams, especially when working in generic models of care.

To use a point from Ashby et al. (2013) study of professional resilience, for all the factors challenging and pushing people to want to leave, there were 999 years of experience working in mental health across the 234 participants involved in the survey. The depth of experience within the participants, and also the OT's relatively new to the field of in mental health, shows their willingness to work with clients in mental health services, and that participants are using the positive aspects of their positions to ensure clients benefit from occupational therapy.

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LIST OF APPENDICIES

Appendix A: Sample of research articles included in literature review 106

Appendix B: Methods: Survey development table 107

Appendix C: Master list of survey questions- Retention of OT's in mental health in NZ. 110

Appendix D: Screenshot example of online Qualtrics survey layout 125

Appendix E: Ethical approval from Otago Polytechnic ethics committee 126

Appendix F: Participant information sheet 127

Appendix G: Email invitation to participate in survey 129

Appendix H: Closing of the survey email 130

Appendix I: Results of survey 131

Appendix A: Sample of research articles included in literature review
(Within parameters of literature search that impacted on the development of the survey instrument)

Article	Source	Design	Numbers	Factors included	Limitations of research
Brintnell, Haglund, Larsson, & Piergrossi (2005)	25 WFOT* countries (A/NZ did not respond)	Questionnaire	25 countries	Totals of OTs working in Mental health Qualifications Demographics Approaches to assessment, treatment intervention and evaluation	Some countries could not access information as no database of requested statistics Findings difficult to draw conclusions due to lack of concise data and consistency A/NZ did not respond so not included in results
Ceramidas, Forn de Zita, Eklund, & Kirsh (2009)	WFOT* (52 of 62 WFOT countries responded)	Cross sectional survey	1345 people from 8 countries	Demographics Service provision Clinical aspects of work Resources available Perceived future for OT's	Data collection and analysis different per country Various healthcare systems Lack of concise definitions due to cultural interpretations A/NZ response rate below 20% so quantitative data not reported
Eklund & Hallberg (2000)	Sweden	questionnaire	334 people	Perceived Job satisfaction	All members of association Issues with survey definitions (e.g. Supervision)
Hayes, Bull, Hargreaves, & Shakespeare (2008)	Australia	Survey	47 people	Perceptions of factors affecting recruitment and retention incl. staying, leaving and future positions	One service in metropolitan area
Hunter and Nicol (2002)	UK, USA	Systematic review	13 articles	Recruitment and retention in response to - Local need - Grade need	All research reviewed looked at different variables
Lloyd, King & Bassett (2002)	Australia	Survey – questionnaire	148 people	Profile of therapists Clinical roles and work activities Generic versus discipline specific work by OT's Future issues of importance to occupational therapists in mental health	All participants members of 'OT Australia' Location of workplace not identified on survey- hospital versus community.
Lloyd, McWha & King (2003)	New Zealand	Cross sectional survey	156 people	Demographics Work profile and activities Generic versus discipline specific work activities Job dissatisfaction sources Sources of stress	Distribution of survey through Association
Panchasharam & Jahrami (2010)	Bahrain	Cross sectional survey	13 people	Job satisfaction	Country specific- Bahrain One setting- hospital based
Scanlan, Still, Stewart, & Croaker (2010)	Australia	Survey	38 people	Perceptions of factors affecting recruitment and retention incl. staying, leaving and future positions	One service in metropolitan area Developed for human resources rather than occupational therapy use
Scanlan and Still (2013).	Australia	Survey	34 people	Measures of job satisfaction, turnover intent and burnout, positive aspects of positions and attracted employees to their current position	One service in metropolitan area Convenient sample, results may not be generalisable Cross sectional so no causality

*WFOT- World Federation of Occupational Therapists

Appendix B: Methods: Survey development table

No.	**Question on current survey**	**Push/ Pull/ Attraction**	**Current/ Future/ Past**	**Current survey Question format**	**Question/ responses adapted from? Factor item list from? Concept from?**
Q.38	Satisfaction On a scale of 1-9, (with 9 being very satisfied and 1 being very dissatisfied) please move the slider to the appropriate number to match your satisfaction:		Current	Likert	Hayes et al. (2008) Q. 3.24 point likert (Scanlan, Still, Stewart, & Croaker, 2010) 4 point Likert Scanlan and Still (2013)10 point Likert
Q 39	your perception of your current position. We would like you to rate the extent to which you agree or disagree with particular aspects being present in your job.	Push and Pull/ depending on viewpoint (see colour coding on results- Appendix X)	Current	Likert (List of factors)	Replication of questions from Scanlan and Still (2013). Also on Likert scale but current survey does not have 'neutral' overtly on scale.
Q 40	what lured you to your current position and why you applied for it? (I was attracted to this job and applied for it…. Because)	Pull/ (Attract)- Lure in	Current	Likert (List of factors)	Hayes et al. (2008) asked this an open ended Q. 12.3. Scanlan et al. (2010) also asked as open ended question. The statements came from Scanlan (2013) survey (p.3) although our layout slightly different. Current survey uses a 6 point strongly agree to strongly disagree, Scanlan had 3 options of not particular attraction, somewhat of an attraction and quite important attraction.
Q. 41	Every job has its stressors and demands, we would like to hear from you what are the most stressful or demanding parts of your current job?	Push	Current	Choose (as many as applicable) (List of factors)	Hayes et al. (2008) open ended 12.5 Scanlan et al. (2010) Open ended. 12.5 What are the constraints on our current job? Scanlan and Still (2013) asked the factors that don't like about current position. Results from these 3 surveys used as part of factor item list. Lloyd, King & Bassett (2002) for nature of work/ focus of work (eg. Role blurring, role conflict), Supervision (Hunter & Nicol,2002),
Q. 44, 45, 46	Content with current position, find another position and actively looking for another job		Current	44- all, only 45 and 46 if yes to Q 44.	Directly from Scanlan and Still (2013) survey.
Q.47	For the following list, please indicate what factors are the most rewarding/ positive aspects of your current position.	Pull	Current	Please select all the aspects that apply to you. (List of factors)	Hayes et al. (2008). Q. 12.4 (Open ended) What are the positive aspects of your current position? Open ended question. Scanlan et al. (2010). As above Scanlan and Still (2013) asked open ended what factors keep you coming back to work each day? (Open ended) PD added in to list from Lloyd, McWha and King (2003) and Ceramidas et al. (2009), Craik (1999), Work/life balance from Scanlan, Meredith and Poulsen (2013). Supervision (Hunter & Nicol (2002) Preferred work is Mental health (Richards, 1998)

					Moore et al. (2006), Scanlan et al. (2010)- Flexibility, Lifestyle (Mills & Millsteed, 2002), Scanlan et al. 2013
Q. 66	please indicate what factors that have helped keep you in your mental health position(s) in the past.	Pull	Past	Same list as Q. 47 Please select all the aspects that apply to you. (List of factors)	Scanlan and Still (2010). 15.1 – asked an open ended question Hayes et al. (2008) Survey asked as above 15.1 Open ended We have used the responses to compile a list of possible factors.
48 (1)	indicate the most important factors that are applicable to the situation described.	push	Current: Factors that might contribute to you leaving or Quitting your **Current job?**	Mark if factor applicable (List of factors)	We developed a table to look to use the same factors for all 3 questions: reduce number of pages of questions with the same factors. 48 (1,2,3) and ensure online survey was completed as much as possible. Scanlan and Still (2013) asked as open ended question Ceramidas et al. (2009)- lack of resources, poor work environment, lack of recognition of OTs (professional identity), Chronicity of clients, caseload, paperwork Richards, (1998) career development, support, staff relationships, personal reasons, (dysfunctional) teams, (Hunter & Nicol, 2002) Supervision Brintnell et al. (2005)- professional identity, physical resources Lloyd, King and Bassett (2002), nature of work/ team Moore et al (2006) Role blurring, professional identity/ role definition and status Freda (1992). Paperwork, increasing productivity expectations, Management issues, team management (Also with Scanlan & Still, 2013; Lloyd, King & Bassett, 2002) Scanlan et al. (2013). Work/life balance, exhaustion, full time vs part time,, flexibility
48 (2)	indicate the most important factors that are applicable to the situation described.	push	Current: Factors that if they were to change, might increase the likelihood that you would **want to leave in the Future**	Mark if factor applicable (List of factors)	As with 48(1) Asked as an open ended question 16.1 on Scanlan et al. (2010). We Took responses and added into our survey list. Scanlan et al, (2010) asked open ended 12.7- what factors would make you consider looking for another position
48 (3)	indicate the most important factors that are applicable to the situation described.	push	Factors that have prompted you to leave in the **Past**	Mark if factor applicable (List of factors)	As with 48(1) 15.2, 15.3 open ended question on Scanlan et al. (2010) Hayes et al (2008) asked what opened ended 15.3 'What factors have prompted you to leave positions in the past?' Bailey, (1990)- Past positions. Salary, location, devalued as OT, lack of understanding of role (role conflict), paperwork, responsibility, stress/ burnout, professional growth/ professional development, lack of respect of OT, career progression, commute, role conflict

49	Hypothetically, what could Lure you away from your current position?	Attraction/ Attract	Current/ future	Please select from the list (List of factors)	Hayes et al. (2008) survey asked what will attract you to future positions. 16.1 Scanlan et al. (2010) also asked this Freda (1992) Professional development, career development, promotion, salary, vacation, responsibilities (more or less), reputation of service, friend recommendation Mills & Millsteed (2002)- Career development opportunities
51	What occupational therapy frames of reference, frameworks or conceptual models guide your current practice?			Please select from the list below (List of 4 choices plus other)	(Ashby, Ryan, Gray, & James, 2013)
52	What other non-occupational therapy models or frames of reference guide your current practice?			Please state: (participants could write in text box)	(Ashby et al., 2013) Ceramidas et al. (2009)

Appendix C: Master list of survey questions- Retention of OT's in mental health in A/NZ

Please be aware that this survey was entered into 'Qualtrics' online survey system not in paper form. The purpose of this appendix is to exhibit the survey questions, coding and display/ flow logic. An example of the 'look and feel' of the survey can be seen in a snapshot in Appendix D.

Q1 Thank you for coming to see if you can help your profession by being a part of Aotearoa New Zealand research!

This survey has been developed for people trained as occupational therapists with an occupational therapy qualification working in mental health in New Zealand and registered with the Occupational Therapy Board of New Zealand (OTBNZ). Your current job title does not need to be Occupational Therapist.

The survey is being conducted to compile information regarding your work, life and decision making about your past, present and future jobs. You have received this because you are associated with an occupational therapy group, a Mental Health special interest group, or a colleague has forwarded it to you.

Your anonymity is assured in completing this survey. No names or contact details are returned to the researcher. Responses to questions will be amalgamated to ensure participants cannot be identified and to ensure anonymity of responses.

For further information, please refer to the link here: Participant info sheet. This is an online survey and once you have completed the survey your data cannot be withdrawn.

As a thank you for completing the survey, you will be eligible to enter a draw for one of two $50 Prezzy gift cards. If you wish to go into the draw you will be asked for your name and contact email at the completion of the survey. This information will not be kept with the survey data, but instead it will be removed by an independent person before data is collated and given to the researcher.

Thank you in advance for your participation. By clicking *next*, you are agreeing to take part in the survey.

NEXT PAGE

Q2 Firstly, we are going to ask some questions about you and your career.

Q3 Are you currently working in mental health in New Zealand?

- ❍ Yes (1)
- ❍ No (2)

Answer If Are you currently working in mental health in New Zealand? Yes Is Selected
Q4 Are you registered with the Occupational Therapy Board New Zealand (OTBNZ)?

- ❍ Yes (1)
- ❍ No (2)

ZONE OUT IF NOT ELIGIBLE: No to Q 3 or 4

Q9 Thank you for your supporting my survey. You have reached this page because your answers to the first two questions mean you do not meet the criteria for inclusion: working in mental health in New Zealand and registered with the Occupational Therapy Board of New Zealand (OTBNZ). If you believe you do meet the criteria and wish to change your responses to reflect your current position, then please contact the survey administrator. stuart.terry@op.ac.nz

Please forward this survey link onto others who work in OT mental health services in New Zealand! Link:

https://otagopolytechnic.asia.qualtrics.com/SE/?SID=SV_7aMScQv8nbM64Bv

CONTINUE ON FOR ELIGIBLE PARTICIPANTS:

Q5 In which geographical location are you based? (Responses to this question will be separated from other data before analysis and amalgamated to ensure anonymity of responses) Please tick one response:

- ❍ Northland (1)
- ❍ Auckland (2)
- ❍ Waikato (3)
- ❍ Bay of Plenty (4)
- ❍ East Coast of North Island (5)
- ❍ Hawke's Bay (6)
- ❍ Taranaki (7)
- ❍ Manawatu-Wanganui (8)
- ❍ Wellington (9)
- ❍ Nelson-Marlborough (10)
- ❍ West Coast of South Island (11)
- ❍ Canterbury (12)
- ❍ Otago (13)
- ❍ Southland (14)

Answer If Are you registered with the Occupational Therapy Board New Zealand (OTBNZ)? No Is Not Selected

Q6 What ethnicities do you most strongly identify with? Select all that apply

- ☐ New Zealand European/Pakeha (1)
- ☐ New Zealand Maori (2)
- ☐ Pacifika (3)
- ☐ NZ (Other) (4)
- ☐ Other please specify (5) _____

Q7 In which age group are you?

- ❍ 20-25 (1)
- ❍ 26-30 (2)
- ❍ 31-35 (3)
- ❍ 36-40 (4)
- ❍ 41-45 (5)
- ❍ 46-50 (6)
- ❍ 51-55 (7)
- ❍ 56-60 (8)
- ❍ 60-64 (9)
- ❍ 65+ (10)

Q69 What gender do you identify with?

- ❍ Male (1)
- ❍ Female (2)

Q10 Now, some questions about your occupational therapy training and career overall

Q11 What year did you qualify to work as an occupational therapist? Please select from the drop down box below

- ❍ 2016 (1)
- ❍ 2015 (57)
- ❍ 2014 (58)
- ❍ 2013 (59)
- ❍ 2012 (60)
- ❍ 2011 (61)
- ❍ 2010 (62)
- ❍ 2009 (63)
- ❍ 2008 (64)
- ❍ 2007 (65)
- ❍ 2006 (66)
- ❍ 2005 (67)
- ❍ 2004 (68)
- ❍ 2003 (69)
- ❍ 2002 (70)
- ❍ 2001 (71)
- ❍ 2000 (72)
- ❍ 1999 (73)
- ❍ 1998 (74)
- ❍ 1997 (75)
- ❍ 1996 (76)
- ❍ 1995 (77)
- ❍ 1994 (78)
- ❍ 1993 (79)
- ❍ 1992 (80)
- ❍ 1991 (81)
- ❍ 1990 (82)
- ❍ 1989 (83)
- ❍ 1988 (84)
- ❍ 1987 (85)
- ❍ 1986 (86)
- ❍ 1985 (87)
- ❍ 1984 (88)
- ❍ 1983 (89)
- ❍ 1982 (90)
- ❍ 1981 (91)
- ❍ 1980 (92)
- ❍ 1979 (93)
- ❍ 1978 (94)
- ❍ 1977 (95)
- ❍ 1976 (96)
- ❍ 1975 (97)
- ❍ 1974 (98)
- ❍ 1973 (99)
- ❍ 1972 (100)
- ❍ 1971 (101)
- ❍ 1970 (102)
- ❍ 1969 (103)
- ❍ 1968 (104)
- ❍ 1967 (105)
- ❍ 1966 (106)
- ❍ 1965 (107)
- ❍ 1964 (108)
- ❍ 1963 (109)
- ❍ 1962 (110)
- ❍ 1961 (111)
- ❍ 1960 (112)
- ❍ 1959 (113)
- ❍ 1958 (114)
- ❍ 1957 (115)
- ❍ 1956 (116)
- ❍ 1955 (117)
- ❍ 1954 (118)

Q12 Since qualifying as an Occupational Therapist, How long (rounded to the nearest year) have you worked in jobs because of your occupational therapy qualification? This includes jobs where the job title was not occupational therapist but used your OT Skills, whether or not you held an annual practicing certificate

Q13 How long (rounded to the nearest year) in total has been in mental health? *(TEXT BOX)*

Q14 How many positions have you held in mental health? *(TEXT BOX)*

Q15 How many years have you been in your current position? *(TEXT BOX)*

Q16 If applicable, can you please state how long (rounded to the nearest year) were you were in the position you held immediately before the position you are in now? *(TEXT BOX)*

Q17 Do you hold a current Annual Practicing Certificate (APC) with the Occupational Therapy Board New Zealand (OTBNZ)?

- ❍ Yes (1)
- ❍ No (2)

Q18 Do you work for a:

- ❑ District Health Board (DHB) (1)
- ❑ Non-Government Organisation (NGO) (2)
- ❑ Private practice (3)
- ❑ Primary Health Organisation (4)
- ❑ Needs Assessment service (5)
- ❑ Other (please specify) (6) _____

Q19 We would like to hear about your current position in mental health. We are aware that service users have different titles: e.g. Consumers, patients, individuals, service users, clients. For the purposes of this survey, we have used the word 'client' for the individuals with whom you work, the consumers of your services.

Q20 What client age group do you currently work with? Select as many as apply

- ❑ Infant, child, adolescent (under 18) (1)
- ❑ Young adult (18-25) (2)
- ❑ Adults (26-64) (3)
- ❑ Older persons (65+) (4)

Q21 In which team and setting do you work with the clients? (please indicate all areas and give an estimated percentage % of your total work time. The total should add up to 100%)

_____ Inpatient acute (1)
_____ Inpatient rehabilitation (2)
_____ First episode team (3)
_____ Community acute/ community assessment team (4)
_____ Crisis team (5)

_____ Day programme (6)
_____ Community continuing care team (7)
_____ Community rehabilitation (8)
_____ Early intervention services (9)
_____ Forensic inpatient services (10)
_____ Forensic community services (11)
_____ Needs Assessment (12)
_____ Drug and alcohol services (13)
_____ Vocational services (14)
_____ Other (please specify) (15)

Q22 We are interested in whether you work as an "Occupational Therapist" or under a different title using your occupational therapy skills.

Q23 What is your job title?

- ❍ Occupational therapist (1)
- ❍ Keyworker (2)
- ❍ Case manager (3)
- ❍ Other: (please specify) (4) _____

Q24 We would like to explore people's current main position in mental health. The terms we have used are: 'Generic'- refers to positions where roles and responsibility are performed by a range of professionals e.g. Case management, care coordination or key workers 'Discipline specific' refers to roles/duties that are specific to the discipline of occupational therapy

Q25 How would you describe your current position in terms of generic vs. discipline specific work?

- ❍ Totally/ almost totally discipline specific (1)
- ❍ More discipline specific than generic (2)
- ❍ About half discipline specific and half generic (3)
- ❍ More generic than discipline specific (4)
- ❍ Totally/ almost totally generic (5)

Q26 Is your manager an occupational therapist?

- ❍ Yes (1)
- ❍ No (2)

Q27 We would like to gather some general information about your work.

Q28 In terms of paid working hours, how many hours a week do you generally work?

Q29 What is your gross annual salary range?

- ❍ 10,001-25,000 (1)
- ❍ 25,001-40,000 (2)
- ❍ 40,001-65,000 (3)
- ❍ 65,001-80,000 (4)
- ❍ 80,001-95,000 (5)
- ❍ Above 95,000 (6)

Q30 If you don't know your annual gross salary, what is your gross before tax hourly rate? (Text Box)

Q31 What other benefits/perks do you have as part of your position? Please select as many as applicable

- ❑ Medical insurance (1)
- ❑ OTNZ-WNA membership (2)
- ❑ Other professional membership (3)
- ❑ Uniform (4)
- ❑ CPD - Continuing Professional Development (5)
- ❑ Discounts/reduced fees (6)
- ❑ Bonus payment (7)
- ❑ On call allowance (8)
- ❑ Vehicle you can take home/use for personal use (9)
- ❑ Vehicle allowance for use of private vehicle (10)
- ❑ Accommodation (11)
- ❑ Laptop/tablet (12)
- ❑ Phone (13)
- ❑ Other not included above, please state (14) _____
- ❑ None of the above (15)

Q32 Do you have senior/management responsibilities in this current position?

- ❍ Yes (1)
- ❍ No (2)

Answer If Do you have senior/management responsibilities in this current position? Yes Is Selected
Q33 For your senior/management responsibilities, how much time is dedicated for senior OT duties such as supervision and co-ordination?

- ❍ Hours per week employed for senior OT duties (1) _____
- ❍ Not applicable (2)

Answer If Do you have senior/management responsibilities in this current position? Yes Is Selected
Q34 If you are in a senior/management position, are you working clinically and/ or as a manager?

- ❍ Clinically (1)
- ❍ Manager (2)
- ❍ Both (3)

Answer If Do you have senior/management responsibilities in this current position? Yes Is Selected
Q35 What is the split of your time between the two roles

Manager (1)
Clinical (2)

Q36 We would like to hear about the things you do in your work role: We are interested in what you spend most of your time doing. Numbering only those you perform indicate what you spend most of your time doing using 1 to indicate most time spent in this role, 2 the next most frequent role And 3 to indicate only from time to time/ if required

	Enter a 1 in this column if most of the time (1)	Enter a 2 in this column the next frequent (2)	Enter a 3 if only time to time (3)
Assessment (1)			
Intervention (2)			
Case Management (3)			
Supervision (4)			
Documentation and administration (5)			
Senior duties (OT related) (6)			
Senior duties (Other professions) (7)			
Other, please specify (8)			

Q37 From this point on in this survey I'm going to be asking you about your perception of your current position - using factors that have been identified in previous research. Not all will apply to you, and some might seem fairly similar, but come from different pieces of research with which I want to compare New Zealand therapist's responses.

Q.38 The following question relates to your current position in mental health:
On a scale of 1-9, (with 9 being very satisfied and 1 being very dissatisfied) circle the appropriate number to match your satisfaction:

1 2 3 4 5 6 7 8 9

Very Dissatisfied Very Satisfied

Q39 The next set of questions are related to your perception of your current position. We would like you to rate the extent to which you agree or disagree with particular aspects being present in your job.

	Strongly Agree (1)	Agree (2)	Somewhat Agree (3)	Somewhat Disagree (4)	Disagree (5)	Strongly Disagree (6)	N/A (7)
The position gives me a chance to use my personal initiative or judgment in carrying out my work (1)	❍	❍	❍	❍	❍	❍	❍
The position requires me to keep track of more than one thing at a time (2)	❍	❍	❍	❍	❍	❍	❍
My position requires a lot of concentration (3)	❍	❍	❍	❍	❍	❍	❍
My contact time with clients is demanding (4)	❍	❍	❍	❍	❍	❍	❍
I always have enough time to perform my tasks (5)	❍	❍	❍	❍	❍	❍	❍
Management decides what everybody has to do (6)	❍	❍	❍	❍	❍	❍	❍
The position gives me considerable opportunity for independence and freedom in how I do the work (7)	❍	❍	❍	❍	❍	❍	❍
My position is emotionally demanding (8)	❍	❍	❍	❍	❍	❍	❍
My position requires me to work very hard (9)	❍	❍	❍	❍	❍	❍	❍
My manager is concerned about the wellbeing of the people that work for her/ him (10)	❍	❍	❍	❍	❍	❍	❍
My position requires me to work very fast (11)	❍	❍	❍	❍	❍	❍	❍
I have good relationships with my colleagues (12)	❍	❍	❍	❍	❍	❍	❍
I receive feedback on my performance from my manager and coworkers (13)	❍	❍	❍	❍	❍	❍	❍
I get enough feedback about the quality of my performance as part of the organisations performance management system (14)	❍	❍	❍	❍	❍	❍	❍
My manager inspires me to do my best work (15)	❍	❍	❍	❍	❍	❍	❍
My colleagues are willing to give me help if I ask for it (16)	❍	❍	❍	❍	❍	❍	❍
My achievements are recognised by my manager (18)	❍	❍	❍	❍	❍	❍	❍
My performance is recognised and rewarded appropriately (19)	❍	❍	❍	❍	❍	❍	❍
I am satisfied with my current pay (20)	❍	❍	❍	❍	❍	❍	❍
My manager uses his/ her influence to help me solve problems (21)	❍	❍	❍	❍	❍	❍	❍
My physical working conditions - climate, noise, design of work place and material are adequate (22)	❍	❍	❍	❍	❍	❍	❍
I think my job is secure (23)	❍	❍	❍	❍	❍	❍	❍
I have good work/ life balance (24)	❍	❍	❍	❍	❍	❍	❍
I have flexibility in the hours I work (25)	❍	❍	❍	❍	❍	❍	❍
The job allows me to make my own decisions about how to schedule my work (26)	❍	❍	❍	❍	❍	❍	❍

Q. 40. The next set of questions are related to your current position, what attracted you to your current position and why you applied for it?
Again, there are a series of statements for you to agree or disagree with. I was attracted and applied for it… Because:

	Strongly Agree (1)	Agree (2)	Somewhat Agree (3)	Somewhat Disagree (4)	Disagree (5)	Strongly Disagree (6)	Not applicable (7)
The organisation had a good reputation (1)	❍	❍	❍	❍	❍	❍	❍
I had a student placement here (2)	❍	❍	❍	❍	❍	❍	❍
The education and training programs offered were good and there were good professional development opportunities (3)	❍	❍	❍	❍	❍	❍	❍
I knew other people who worked here/ recommended by a friend (4)	❍	❍	❍	❍	❍	❍	❍
I was interested in the opportunities to develop skills (5)	❍	❍	❍	❍	❍	❍	❍
The work was interesting and challenging (6)	❍	❍	❍	❍	❍	❍	❍
I was interested in the clinical role/ nature and type of work involved in the role (7)	❍	❍	❍	❍	❍	❍	❍
The salary was good (8)	❍	❍	❍	❍	❍	❍	❍
I'd heard that the particular team was good- supportive and worked well as a team (9)	❍	❍	❍	❍	❍	❍	❍
I was just applying for whatever jobs were available (10)	❍	❍	❍	❍	❍	❍	❍
The service/ team used evidence based/ best practice methods (11)	❍	❍	❍	❍	❍	❍	❍
There was opportunity for involvement in research (12)	❍	❍	❍	❍	❍	❍	❍
There was opportunity for involvement in quality improvement (13)	❍	❍	❍	❍	❍	❍	❍
I thought the service offered good career opportunities (14)	❍	❍	❍	❍	❍	❍	❍
I'd worked for the organization before and felt comfortable there (15)	❍	❍	❍	❍	❍	❍	❍
The organization/ team appeared dynamic and/ or had a strong vision (16)	❍	❍	❍	❍	❍	❍	❍
I was interested in working in mental health (17)	❍	❍	❍	❍	❍	❍	❍
The position would offer me the opportunity for flexibility and lifestyle needs (working hours, study leave or childcare) (18)	❍	❍	❍	❍	❍	❍	❍
There appeared to be a lot of variety in the role (19)	❍	❍	❍	❍	❍	❍	❍
The role offered me more responsibility (20)	❍	❍	❍	❍	❍	❍	❍
The role offered me less responsibility (21)	❍	❍	❍	❍	❍	❍	❍
The location was good (22)	❍	❍	❍	❍	❍	❍	❍
The resources and infrastructure available were good (23)	❍	❍	❍	❍	❍	❍	❍
The team had a high regard for occupational therapy (26)	❍	❍	❍	❍	❍	❍	❍
The position fitted with my childcare needs (27)	❍	❍	❍	❍	❍	❍	❍
It allowed me to work in the same location as my partner (28)	❍	❍	❍	❍	❍	❍	❍
Other, please specify (24)	❍	❍	❍	❍	❍	❍	❍

Q41 Every job has its stressors and demands, we would like to hear from you what are the most stressful or demanding parts of your current job?

Please select from the following list. You can chose as many or as few as you think applicable.

- ❑ Lack of respect or understanding of the OT profession from OT team (1)
- ❑ Lack of respect or understanding about OT from other professions or team (3)
- ❑ Members' opinions of Occupational Therapy (4)
- ❑ Continually having to justify OT services (6)
- ❑ Role conflict/ role blurring with other professions (7)
- ❑ Excessive paperwork (8)
- ❑ Red tape and bureaucracy (10)
- ❑ Lack of career advancement (11)
- ❑ Stress/ Overload (12)
- ❑ Increasing/ Too high of a case load/ caseload size (13)
- ❑ Generic work/ Not using OT skills (14)
- ❑ Multiple demands (15)
- ❑ Daily dealing of trauma and pain (16)
- ❑ Chronicity of clients (17)
- ❑ Difficulty coping with job (18)
- ❑ Inflexible/long hours/ insufficient time for position expectation (19)
- ❑ Distance from home (commute) (20)
- ❑ Childcare issues (21)
- ❑ Lack of supervision (22)
- ❑ Student supervision (23)
- ❑ Peer relationships (25)
- ❑ Management style of team (26)
- ❑ Other: please specify (27) _____

Q42 The next question/s relate to whether you are currently considering leaving your current position.

Q43 I am content with my current position and wish to remain in this position.

- ❍ Yes (1)
- ❍ No (2)

Answer If I am content with my current position and wish to remain in this position. No Is Selected
Q44 I often think about quitting my job.

- ❍ Yes (1)
- ❍ No (2)

Answer If I am content with my current position and wish to remain in this position. No Is Selected
Q45 As soon as I can find another job, I will quit.

- ❍ Yes (1)
- ❍ No (2)

Answer If I am content with my current position and wish to remain in this position. No Is Selected
Q46 I am actively looking for another job.

- ❍ Yes (1)
- ❍ No (2)

Q47 Next, we want to hear which aspects might be most rewarding, contribute to you leaving or attract you to a job in the future. These factors/ aspects have been compiled from previous research. For the following list, please indicate what factors are the most rewarding/ positive aspects of your current position. Please select all the aspects that apply to you.

- ❑ Direct client contact (1)
- ❑ Nature of caseload (2)
- ❑ Program development (3)
- ❑ Staff supervision (4)
- ❑ Clinical research (5)
- ❑ Student supervision (6)
- ❑ Management responsibilities (7)
- ❑ Participation in service activities (8)
- ❑ Child care (9)
- ❑ Holiday/ Vacation time (10)
- ❑ Continuing education/ Professional development (11)
- ❑ Salary/ Pay (12)
- ❑ Caseload (13)
- ❑ Supervision (14)
- ❑ Relationship with supervisor (15)
- ❑ Team opinion of occupational therapy (16)
- ❑ Management style of team (17)
- ❑ Flexibility of hours (19)
- ❑ Promotion/ career development (20)
- ❑ Opportunity for professional growth. (21)
- ❑ Work/ life balance (23)
- ❑ Relationship with team and peers (24)
- ❑ Other(please insert) (25) _____

Q66 For the following list, please indicate what factors that have helped keep you in your mental health position(s) in the past. Please select all the aspects that apply to you.

- ❑ Direct client contact (1)
- ❑ Nature of caseload (2)
- ❑ Program development (3)
- ❑ Staff supervision (4)
- ❑ Clinical research (5)

- ❑ Student supervision (6)
- ❑ Management responsibilities (7)
- ❑ Participation in service activities (8)
- ❑ Child care (9)
- ❑ Holiday/ Vacation time (10)
- ❑ Continuing education/ Professional development (11)
- ❑ Salary/ Pay (12)
- ❑ Caseload (13)
- ❑ Supervision (14)
- ❑ Relationship with supervisor (15)
- ❑ Team opinion of occupational therapy (16)
- ❑ Management style of team (17)
- ❑ Flexibility of hours (19)
- ❑ Promotion/ career development (20)
- ❑ Opportunity for professional growth. (21)
- ❑ Work/ life balance (23)
- ❑ Relationship with team and peers (24)
- ❑ Other(please insert) (25) _____

Q48 For each column indicate the most important factors that are applicable to the situation described.

	Factors that might contribute to you leaving/ quitting your CURRENT job: (1)	Factors that if they were to change, might increase the likelihood that you would want to leave in the FUTURE? (2)	Factors that have prompted you to leave in the PAST? (3)
Lack of respect or understanding of the OT profession from OT team (1)	❑	❑	❑
Lack of respect or understanding about OT from other professions or team members' opinions of occupational therapy (2)	❑	❑	❑
Continually having to justify OT services (6)	❑	❑	❑
Role conflict/ role blurring with other professions (7)	❑	❑	❑
Excessive paperwork (8)	❑	❑	❑
Salary (9)	❑	❑	❑
Red tape and bureaucracy (10)	❑	❑	❑
Lack of career advancement (11)	❑	❑	❑
Stress/ Overload (12)	❑	❑	❑
Increasing/ Too high of a case load/ caseload size (13)	❑	❑	❑
Generic work/ Not using OT skills (14)	❑	❑	❑
Multiple demands (15)	❑	❑	❑
Daily dealing of trauma and pain (16)	❑	❑	❑
Chronicity of clients (17)	❑	❑	❑
Difficulty coping with job (18)	❑	❑	❑
Inflexible/long hours/ insufficient time for position expectation (19)	❑	❑	❑
Distance from home (commute) (20)	❑	❑	❑
Childcare issues (21)	❑	❑	❑
Lack of supervision (22)	❑	❑	❑
Student supervision (23)	❑	❑	❑
Marriage (25)	❑	❑	❑
Relocation of spouse (26)	❑	❑	❑
Birth of child (27)	❑	❑	❑
Desire to move to new geographical location (28)	❑	❑	❑
Opportunities for further Education/ Additional degree/ Professional growth (29)	❑	❑	❑
Promotion/ career development (30)	❑	❑	❑
Peer relationships (31)	❑	❑	❑
Management style of team (32)	❑	❑	❑
Other: please specify (33)	❑	❑	❑

Q49 Hypothetically, what could lure you away from your current position? Please select from the list below.

- ❑ Higher salary (1)
- ❑ Promotion/ career development (2)
- ❑ More continuing education/ Professional development/ Further education/ additional qualifications (3)
- ❑ Less responsibility (4)
- ❑ More responsibility (5)
- ❑ More vacation time (6)
- ❑ Flexibility in hours (7)
- ❑ Child care (8)
- ❑ Team opinion of occupational therapy (9)
- ❑ Workplaces reputation (10)
- ❑ Management style of team (11)
- ❑ Recommendation of friend (12)
- ❑ Increase in Supervision (13)
- ❑ Decrease/change in nature of caseload in new position (14)
- ❑ Decrease in paperwork (15)
- ❑ Marriage (16)
- ❑ Relocation of spouse (17)
- ❑ Birth of child (18)
- ❑ Desire to move to new geographic location (19)
- ❑ Other, please specify (20) _____

Q50 In our final few questions, we are interested in your occupational therapy guiding frames of reference, frameworks or conceptual models and their relevance to people's satisfaction with their job.

Q51 What occupational therapy frames of reference, frameworks or conceptual models guide your current practice? (Please select from the list below)

- ❑ Model of Human Occupation (MOHO) (1)
- ❑ Person Environment Occupation (PEO) (2)
- ❑ Canadian Model of Performance and Engagement (CMOP-E) (3)
- ❑ Kawa Model (4)
- ❑ Other, please specify (5) _____

Q52 What other non-occupational therapy models or frames of reference guide your current practice? Please state: *(TEXT BOX)*

Q53 If there are any comments, related to what might help you stay or go from a job, that you would like to make that have not been addressed elsewhere, please feel free to make them here. (TEXT BOX)

Q65 Thank you for your time in completing this survey. If you would like to be in the draw for one of two $50 prezzy cards, please enter your name and contact email in the box below (optional). This information will not be attached to the survey and is removed by an independent person before data is collated and given to the researcher. Please forward this survey link onto others who work in mental health services in New Zealand!

Link: https://otagopolytechnic.asia.qualtrics.com/SE/?SID=SV_7aMScQv8nbM64Bv

Name (1)
Email address (2)
or contact phone (3)

Q64 If upon completing this questionnaire, you would be interested in being part of future work on factors looked at in this survey, please leave your name and contact email below. This will not be attached to the survey responses and is removed by an independent person who will compile a separate list. If completing this questionnaire has raised any concerns or issues for you, please contact your employee assistance program which can offer free, professional and strictly confidential counselling and support services. Your GP can also guide you in services you can access.

A summary of the survey results will be sent out via the mental health special interest group and placed on the Otago Polytechnic OT Facebook page.

Name (1), Email Address (2), or contact phone (3)

Q68 We would like to acknowledge the work of the following sources in aspects of the development of the survey:

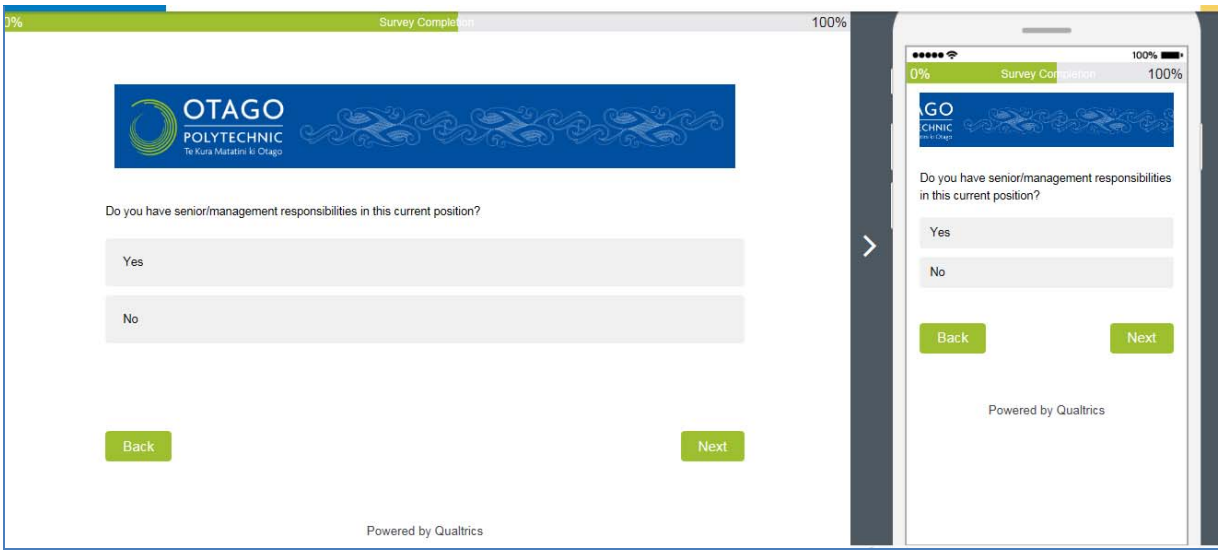
Hayes, R., Bull, B., Hargreaves, K. and Shakespeare, K. (2008). A survey of recruitment and retention issues for occupational therapists working clinically in mental health. *Australian Occupational Therapy Journal, 55*: 12–22. doi: 10.1111/j.1440-1630.2006.00615.x

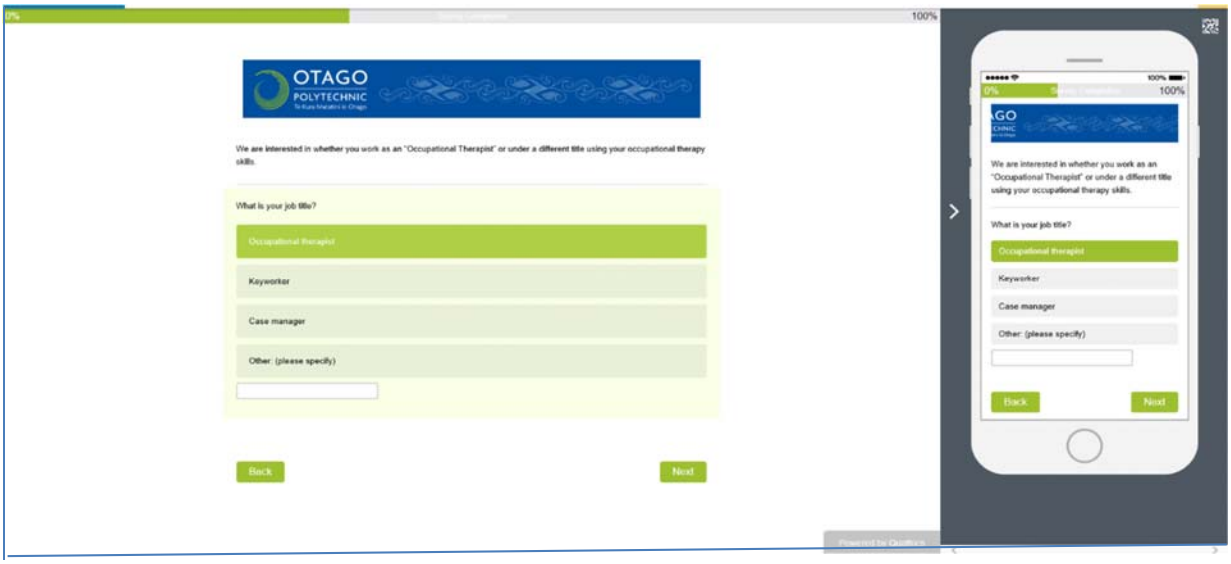
Scanlan, J. N., Still, M., Stewart, K. and Croaker, J. (2010). Recruitment and retention issues for occupational therapists in mental health: Balancing the pull and the push. *Australian Occupational Therapy Journal, 57*: 102–110. doi: 10.1111/j.1440-1630.2009.00814.x

Scanlan, J. N., & Still, M. (2013). Job satisfaction, burnout and turnover intention in occupational therapists working in mental health. *Australian Occupational Therapy Journal*, *60*(5), 310–8. https://doi.org/10.1111/1440-1630.1206

Appendix D: Screenshot example of online Qualtrics survey layout

Examples of questions for desktop (right) and also tablet/ phone (left).





Appendix E: Ethical approval from Otago Polytechnic ethics committee

16 October 2015

Jayne Webster

2/15 Charlemont Street,
Whitiora
Hamilton 3200

Dear Jayne

Re: Application for Ethics Consent
Reference Number: 624
Application Title: *Should I stay or should I go? Factors influencing retention of occupational therapists working in mental health services in New Zealand*

Thank you for your application for ethics approval for this project.

The review panel has considered your revised application including responses to questions and issues raised. We are pleased to inform you that we are satisfied with the revisions made and confirm ethical approval for the project.

We wish you well with your work and remind you that at the conclusion of your research you should send a brief report with findings and/or conclusions to the Ethics Committee. All correspondence regarding this application should include the reference number assigned to it.

Regards

E. Tumilty

Emma Tumilty
Deputy Chair, Ethics Committee
Otago Polytechnic

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Phone +64 3 477 3014
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Appendix F: Participant information sheet

Retention of Occupational Therapists working in Mental Health Services in New Zealand- Participant information Sheet

What is this survey about?
The research aims to explore the factors that influence a person's past, present and future positions in mental health and occupational therapy. We are looking at the factors that influence whether a person chooses to stay in or leave mental health positions or is influencing the retention of staff.

Who can take part/ who is being asked to participate?
This survey is open to anyone who currently works in mental health services in New Zealand, is a registered occupational therapist with the Occupational Therapy Board of New Zealand and utilizes occupational therapy skills in their position (so, your position title does not have be occupational therapist).

What does the study involve?
The study involves completing an online survey. The survey will take approx. 15 minutes to complete (depending on your choices) and the information you supply will be an important contribution to examining the retention of mental health occupational therapy personnel specifically in New Zealand. You do not have to answer all the questions in order to complete the survey.

Ethics
Ethical approval for this study has been given by Otago Polytechnic Ethics Committee. OTNZ-WNA and OTBNZ have given their approval for this research to be distributed. This study is entirely voluntary. The clicking of next on the first page of the survey, is your consent to agreeing to participate in the survey, however, you can withdraw up until you click the submit button on the final page of the survey.

Who is the researcher?
I have worked in mental health services in both New Zealand and in the USA. As a researcher, I am interested in knowing about what encourages people to stay and what factors play into OT's leaving positions based in mental health services. In completing this survey you are providing data that contributes to the wider understanding of the factors that influence staff retention in mental health services in New Zealand. The research is being undertaken as part of a Masters in Occupational Therapy through Otago Polytechnic.

What will happen to the data you provide?
The survey is completed online and the information you provide is collated and sent to the researcher so your reply is anonymous. You will not be personally identified in any reports

resulting from the survey. Data may be used for conference presentations and may be submitted as articles to academic and professional journals. By completing this survey, you are giving consent to use the information as described above. This is an online survey and once you have completed the survey your data cannot be withdrawn. Data will be securely stored at the Otago Polytechnic for 5 years and then destroyed and deleted.

A summary of the research will be sent out via the OTNZ-WNA mental health special interest forum and a link will be available via the Otago Polytechnic School of Occupational Therapy Facebook page.

Can I tell others people about the study?
You are welcome to tell others about the study. We would encourage you to encourage other occupational therapists working in mental health to participate in the survey.
I would be delighted to receive a completed survey from you and thank you in advance for your input. If you have any questions or queries, now or into the future, please do not hesitate to contact myself or my supervisors at the contact details given below.

Yours sincerely

Researcher: Jayne Webster, jwebster@op.ac.nz, Otago Polytechnic, School of Occupational Therapy, Private Bag, Dunedin. Ph. (07) 834 8800 x3092
Supervisors: Dr. Michael Gaffney on Michael.gaffney@op.ac.nz
Dr. Linda Wilson

Appendix G: Email invitation to participate in survey

Dear occupational therapist/ key worker/ case manager with a practicing certificate working in mental health services in New Zealand.

This is an invitation to be a part of a survey contributing towards research entitled:

"Should I stay or should I go?" - Factors influencing retention of occupational therapists working in mental health services in New Zealand

Do you work with people who have mental health issues in NZ by using your occupational therapy skills (your position title does not have be occupational therapist)?

As long as you are registered with the Occupational Therapy Board of New Zealand (OTBNZ), we invite you to take part in a survey that will help us understand factors influencing retention for occupational therapists working in New Zealand mental health services. We hope the results would be to develop retention strategies which benefit consumers, therapists and the profession.

Eligible participants who complete this survey will be offered an opportunity to win a one of 2 $50 prezzy cards.

Click on the link here to find out more:
https://otagopolytechnic.au1.qualtrics.com/SE/?SID=SV_eW3lUH9jh8wgyaN
(Anonymous Survey Link)

Thank you for your participation in advance. If you have any questions about the research, either now or in the future, please feel free to contact either:

Jayne Webster, jwebster@op.ac.nz, Otago Polytechnic, School of Occupational Therapy, Private Bag, Dunedin. Ph. (07) 834 8800
Dr. Michael Gaffney on Michael.gaffney@op.ac.nz
Dr. Linda Wilson on linda.wilson@op.ac.nz

Appendix H: Closing of the survey email.

Kia ora,

Thank you to all occupational therapists/ key workers/ case managers that have taken time to complete the survey “Should I stay or should I go?” - Factors influencing retention of occupational therapists working in mental health services in New Zealand.

We have had an amazing response from people working in mental health in New Zealand and registered with the Occupational Therapy Board of New Zealand (OTBNZ). We would love to hear from anyone else who is eligible to undertake the survey. We will be closing the link after Sunday 29th May. The survey link is embedded below in the original invitation. Feel free to forward onto others you think may not have seen the invitation.

Mauruuru koe

Jayne Webster, Dr. Michael Gaffney and Dr. Linda Wilson.

Appendix I: Results of survey

Matching with survey questions- Please note that the Question numbering relates to the 'Master list of survey questions' (Appendix C).

Section 1: Inclusion Criteria

Opened link to survey from invite		283
Opened up link to survey and proceeded to answer 1		274
Q 3: Are you currently working in mental health services in New Zealand? (forced choice- inclusion criteria)		
n= 274	Yes	No
	237	37
Q. 4: Are you registered with the Occupational Therapy Board New Zealand (OTBNZ)? forced choice- inclusion criteria) Eligible to proceed into this question: n= 237		
n= 237	Yes	No
	234	3
234 eligible to response to rest of survey. 234 participants are approx. 68% of OT's who identify as working in mental health.		

Section 2: Who are the participants?

Q. 5: In which geographical location are you based? (Responses to this question will be separated from other data before analysis and amalgamated to ensure anonymity of responses) Please tick one response:

N = 233	n=233	%
Northland/ Auckland	79	34%
Waikato/ Bay of Plenty	47	20%
East Coast of North Island Hawke's Bay/ Taranaki /Manawatu-Wanganui Wellington	36	16%
Canterbury	30	13%
Otago/ Southland	24	11%
Nelson-Marlborough/ West Coast of South Island	15	6%

Q.6: What ethnicities do you most strongly identify with? Select all that apply

	n=233	%
New Zealand European/Pakeha	185	74
NZ Maori	15	6
Pacifika	4	2
UK/ European	21	8
South African	9	4
Asian	5	2
NZ other	5	2
6 other (incl. Australia)	6	2
Total number of responses	250	100%

Q.7: In which age group are you?

age:	n= 232
20-25	27
26-30	20
31-35	31
36-40	35
41-45	33
46-50	29
51-55	27
56-60	21
60-64	6
65+	3

Q.69: What gender do you identify with?

	n=163	
Male	13	8%
Female	150	92%

Section 3: Working life: Work of the participants:

Now, some questions about your occupational therapy training and career overall

Q11 What year did you qualify to work as an occupational therapist?

Years since qualifying	Year chosen on drop down	N= 227
New Grad- 1 year	2015-2016	15
2-5 years	2014-2011	51
0-5	2016-2011	66
6-10	2010-2006	36
11- 15	2005-2001	24
16- 20	2000-1996	35
21- 25	1995-1991	18
26- 30	1990-1986	20
31-35	1985- 1981	13
36 plus	1980-1966	15

Q. 12: Since qualifying as an Occupational Therapist, how long (rounded to the nearest year) have you worked in jobs because of your occupational therapy qualification? This includes jobs where the job title was not occupational therapist but used your OT Skills, whether or not you held an annual practicing certificate

Years	n= 225
0-1	*19*
0-5	72
6-10	36
11-15	25
16-20	37
21-25	19
26-30	20
31 plus	16

Q13 How long (rounded to the nearest year) in total has been in mental health?

Years	n= 226
0-1	*29*
0-5	79
6-10	51
11-15	32
16-20	35
21-25	14
26-30	10
31 plus	5

Q14 How many positions have you held in mental health?

No of positions	n= 225
1	55
2	33
3	36
4	31
5	20
6	17
7	7
8	15
9	4
10	3
11	0
12	2
13	0
14	1
15	0
16+	1

Q15 How many years have you been in your current position?

years in current position	n=223	notes
0	6	rounding system used so less than 6 months
1	63	
2	46	
3	22	
4	15	
5	12	5 years or less
6	14	
7	7	
8	9	
9	4	
10	6	
11	0	
12	3	
13	2	
14	1	
15	2	
16 + years	11	

Q16 If applicable, can you please state how long (rounded to the nearest year) were you were in the position you held immediately before the position you are in now?

No of years	n= 197	notes
0	14	Less than 6 months
1	47	
2	49	
3	24	
4	15	
5	16	
6	4	
7	8	
8	2	
9	7	
10	5	
11	0	
12	2	

13	0	
14	0	
15	2	
16 + years	2	

Q17 Do you hold a current Annual Practicing Certificate (APC) with the Occupational Therapy Board New Zealand (OTBNZ)?

n= 225	yes	no	notes
Annual Practicing Certificate (APC)	222	3	From the original 234 eligible, n= 225 so 9 people did not respond

Section 4- Your current position in mental health:

Q.18: Do you work for a:

n= 224	n= 224
DHB	170
NGO-	35
PP-	16
PHO-	4
Needs assessment service-	2
Government agencies-(MOE and government department)	2
Education- (tertiary institution and training establishments)	3

Q. 20: client age group do you currently work with? Select as many as apply

	As per survey division		Aggregated data	
	n= 225	%	n= 225	%
Infant, child, adolescent (under 18)	58	25.8	58	25.8
Young adult (18-25)	105	46.7	175* (18-64 age)	77.8*
Adults (26-64)	166	73.8		
Older persons (65+)	56	24.9	56	24.9
Total responses	385		289	

- Combination of young adults and adult. If participant checked both, then this was counted as one.

Q21 In which team and setting do you work with the clients? (Recorded during analysis as number of participants who responded as opposed to survey question of percentage of time)

	Number of people who responded:	n= 225
Code number	Setting/ team	
7	Community continuing care team	49
8	Community rehabilitation	48
1	acute inpatient	44
4	Community acute/ community assessment team	36
2	Inpatient rehabilitation	19
19	management, training/education, resourcing, community development, Coordination	18
5	Crisis team	14
10	Forensic inpatient services	13
13	Drug and alcohol services	11
15	other	11
16	Brief intervention/ primary health/ private practice	11
9	Early intervention services	10
12	Needs Assessment	10
18	Specialist service	9
6	Day programme	8
11	Forensic community services	8
14	Vocational services	8
17	Child adolescent youth MHS	7
3	First episode team	4
sum of responses:		338

Q. 22: We are interested in whether you work as an "Occupational Therapist" or under a different title using your occupational therapy skills.

Job title:	n= 220
Occupational therapist	131
Keyworker/ case manager	19
Manager (management)	19
Coordinator/ Supervisor	16
Education/ development/facilitator	8
Health professional/ clinician/ therapist	3
Contractor/ Private Practice	3
Other	1

Q. 23: How would you describe your current position in terms of generic vs. discipline specific work?

- Totally/ almost totally discipline specific (1)
- More discipline specific than generic (2)
- About half discipline specific and half generic (3)
- More generic than discipline specific (4)
- Totally/ almost totally generic (5)

	n= 221	%
Totally/ almost totally discipline specific	45	20.4
More discipline specific than generic	38	17.2
About half discipline specific and half generic	52	23.5
More generic than discipline specific	53	24
Totally/ almost totally generic	33	14.9

Q26 Is your manager an occupational therapist?

- Yes (1)
- No (2)

OT manager?	n= 212	%
Yes	25	11.8
No	187	88.2

Q28 In terms of paid working hours, how many hours a week do you generally work?

Hours	n=204	%
<20	9	4.4
20-30	28	13.7
31-39	28	13.7
40	132	64.7
>40	7	3.4
Average		36.3

Q29 What is your gross annual salary range? (Incorporated where possible: Q30 If you don't know your annual gross salary, what is your gross before tax hourly rate?)

Pay range $	n= 216	%
10,001-25,000	6	2.8
25,001-40,000	18	8.3
40,001-65,000	91	42.1
65,001-80,000	77	35.7
80,001-95,000	14	6.5
Above 95,000	10	4.6

Q31 What other benefits/perks do you have as part of your position? Please select as many as applicable

Perk/ Benefit	n=197
CPD - Continuing Professional Development	116
Phone	82
OTNZ-WNA membership	82
Discounts/reduced fees	41
Laptop/tablet	19
Other professional membership	18
None of the perks from list (‘none of the above’)	15
On call allowance	13
Vehicle allowance for use of private vehicle/ travel allowance	12
APC	12
Medical/life/ income insurance	11
Vehicle you can take home/use for personal use	9
Uniform/ clothing allowance	7
Flex time/ flex leave/ extra leave	6
Bonus payment/ penal rates	4
OT registration	3
Health/ Medical/ fitness perks	2
Accommodation	1
External supervision	1
Tax deductive expenses	1
Number of responses	455

Q32 Do you have senior/management responsibilities in this current position?

	n= 221	%
Yes	78	35.3
No	143	64.7

Q. 33: For your senior/management responsibilities, how much time is dedicated for senior OT duties?

(For your senior/management responsibilities, how much time is dedicated for senior OT duties such as supervision and co-ordination?

- Hours per week employed for senior OT duties (1) _____
- Not applicable (2)

hours per week	n= 45
1-5	16
6-10	10
11-15	2
16-20	13
21-25	2
26-30	1
31-35	0
36-40	1
N/A	27

Q. 34: If you are in a senior/management position, are you working clinically and/ or as a manager?

- Clinically (1)
- Manager (2)
- Both (3)

	n= 72	%
Clinically	31	43
Manager	12	17
Both	29	40

Q35 What is the split of your time between the two roles

Manager (1)
Clinical (2)
No results- Unable to record as time split during analysis

Q. 36: We would like to hear about the things you do in your work role: We are interested in what you spend most of your time doing. Numbering only those you perform indicate what you spend most of your time doing using 1 to indicate most time spent in this role, 2 the next most frequent role And 3 to indicate only from time to time/ if required

	Enter a 1 in this column if most of the time (1)	Enter a 2 in this column the next frequent (2)	Enter a 3 if only time to time (3)

A- People who use the following skills/ tasks as part of their role Checked in either column: 1,2,3)
B- With weighting

n= 211	Column A (%)	Column B
Intervention	n=187 (87%)	473
Documentation and admin	n=182 (86%)	417
Assessment	n=179 (85%)	391
Supervision	n=146 (69%)	227
Case management	n=128 (61%)	295
Senior duties (OT related)	n=93 (44%)	145
Senior duties (other professions)	n=79 (37%)	140
Training/ education of staff	n=9 (4%)	9
Business management/ promotion/ community liaison	n=4 (2%)	4
Total number of responses	1007	

Individual breakdown:

	A	weighing	B
people use Intervention most of the time in their current position	118	3	354
people use Intervention next	50	2	100
people use Intervention from time to time	19	1	19
TOTAL people use Intervention as part of their position	187		473

documentation and admin	A	weighing	B
people use documentation and admin most of the time in their current position	78	3	234
people use documentation and admin next	79	2	158
people use documentation and admin from time to time	25	1	25
TOTAL people use documentation and admin as part of their position	182		417

Task/ skill of assessment:	A	weighing	B
people use assessment most of the time in their current position	65	3	195
people use assessment next	82	2	164
people use assessment from time to time	32	1	32
TOTAL people use assessment as part of their position	179		391

supervision	A	weighting	B
people use supervision most of the time in their current position	14	3	42
people use supervision next	53	2	106
people use supervision from time to time	79	1	79
TOTAL people use supervision as part of their position	146		227

case management	A	weighting	B
people use case management most of the time in their current position	69	3	207
people use case management next	29	2	58
people use case management from time to time	30	1	30
TOTAL people use case management as part of their position	128		295

senior duties (OT related)	A	weighting	B
people use senior duties (OT related) most of the time in their current position	13	3	39
people use senior duties (OT related) next	26	2	52
people use senior duties (OT related) from time to time	54	1	54
TOTAL people use senior duties (OT related) as part of their position	93		145

senior duties (other professions)	A	weighting	B
people use senior duties (other professions) most of the time in their current position	24	3	72
people use senior duties (other professions) next	13	2	26
people use senior duties (other professions) from time to time	42	1	42
TOTAL people use senior duties (other professions) as part of their position	79		140

Other activities:

4 people undertook business management, promotion and community liaison as part of their work.

9 people undertook training and education of staff as part of their work.

Section 5: Satisfaction

The following question relates to your current position in mental health: On a scale of 1-9, (with 9 being very satisfied and 1 being very dissatisfied) please move the slider to the appropriate number to match your satisfaction:

Rating on Likert	n=	%	
9	16	8%	Very satisfied
8	39	19%	
7	57	28%	
6	41	20%	
5	14	7%	
4	12	6%	
3	8	4%	
2	4	2%	
1	11	6%	Very dissatisfied
total:	N= 202	100%	

Q39 The next set of questions are related to your perception of your current position. We would like you to rate the extent to which you agree or disagree with particular aspects being present in your job

IF AGREE- then PULL IF AGREE THEN PUSH NEITHER AS DEPENDS OF VIEW OF PERSON if this is a push or pull	Strongly Agree (1)	Agree (2)	Somewhat Agree (3)	Agree total	Somewhat Disagree (4)	Disagree (5)	Strongly Disagree (6)	Disagree total	Total
The position gives me a chance to use my personal initiative or judgment in carrying out my work (1)	101	76	16	193	4	1	3	8	201
The position requires me to keep track of more than one thing at a time (2)	148	44	4	196	3	0	0	3	199
My position requires a lot of concentration (3)	111	65	20	196	2	1	1	4	201
My contact time with clients is demanding (4)	69	60	42	171	8	11	4	23	194
I always have enough time to perform my tasks (5)	10	28	47	85	33	42	41	116	201
Management decides what everybody has to do (6)	12	21	52	85	45	42	24	111	196
The position gives me considerable opportunity for independence and freedom in how I do the work (7)	65	71	41	177	10	11	2	23	200
My position is emotionally demanding (8)	70	74	37	181	11	6	2	19	200
My position requires me to work very hard (9)	66	85	31	182	11	5	1	17	199
My manager is concerned about the wellbeing of the people that work for her/ him (10)	48	71	36	155	17	9	12	38	197
My position requires me to work very fast (11)	19	61	70	150	30	14	4	48	198
I have good relationships with my colleagues (12)	82	83	26	191	4	2	1	7	198
I receive feedback on my performance from my manager and coworkers (13)	35	67	52	154	23	10	7	40	194
I get enough feedback about the quality of my performance as part of the organisations performance management system (14)	28	50	43	121	38	22	13	73	194
My manager inspires me to do my best work (15)	31	50	58	139	27	12	15	54	193
My colleagues are willing to give me help if I ask for it (16)	66	86	33	185	9	2	0	11	196
My achievements are recognised by my manager (18)	37	62	42	141	22	17	12	51	192
My performance is recognised and rewarded appropriately (19)	19	39	52	110	40	32	12	84	194
I am satisfied with my current pay (20)	15	44	45	104	38	32	24	94	192
My manager uses his/ her influence to help me solve problems (21)	31	57	57	145	15	16	14	45	190
My physical working conditions - climate, noise, design of work place and material are adequate (22)	24	50	45	119	42	18	21	81	200
I think my job is secure (23)	39	90	42	171	12	4	10	26	197
I have good work/ life balance (24)	27	87	44	159	25	7	6	38	197
I have flexibility in the hours I work (25)	26	54	48	128	32	36	11	69	197
The job allows me to make my own decisions about how to schedule my work (26)	53	80	35	168	18	12	2	32	200

Factors Rated According to View of Current Position

Q39	Satisfaction Correlation r value	Strongly Agree (1) Agree (2)	Neutral (3),(4)	Disagree (5) Strongly Disagree (6)	Total
use my personal initiative or judgment (1)	0.545*	177	20	4	201
My manager is concerned about the wellbeing of the people that work for her/ him (10)	0.483*	119	53	21	197
My manager inspires me to do my best work (15)	0.482*	81	85	27	193
achievements are recognised by my manager (18)	0.456*	99	64	29	192
performance is recognised and rewarded appropriately (19)	0.436*	58	92	44	194
independence and freedom in how I do the work (7)	0.430*	136	51	13	200
My manager uses his/ her influence to help me solve problems (21)	0.403*	88	72	30	190
good work/ life balance (24)	0.393*	114	69	13	197
flexibility in the hours (25)	0.360*	80	80	47	197
My colleagues are willing to give me help if I ask for it (16)	0.349*	152	42	2	196
My physical working conditions are adequate (22)	0.347*	74	87	39	200
feedback on performance via performance management system (14)	0.338*	78	81	35	194+7
own decisions about how to schedule my work (26)	0.335*	133	53	14	200
Satisfaction- my current pay (20)	0.289	59	83	56	192
performance feedback from my manager and co-workers (13)	0.288	102	75	17	194
good relationships with my colleagues (12)	0.279	165	30	3	198
job is secure (23)	0.270	129	54	14	197
Multitasking (2)	0.265	192	7	0	199
enough time to perform my tasks (5)	0.246	38	80	83	201
concentration (3)	0.176	176	22	2	201
My contact time with clients is demanding (4)	0.085	129	50	15	194
work very hard (9)	0.041	151	42	6	199
work very fast (11)	-0.038	80	100	18	198
emotionally demanding (8)	-0.108	144	48	8	200
Management decides what everybody has to do (6)	-0.238	33	97	66	196

Q 40. Factors about why Participants were Attracted to Current Position

	Satisfaction Correlation R value	Strongly Agree (1) Agree (2)	Neutral(3), (4)	Disagree (5) Strongly Disagree (6)	Total
The work was interesting and challenging (6)	0.406*	159	31	4	194
The team had a high regard for occupational therapy (26)	0.345*	76	70	29	175
opportunity for flexibility and lifestyle needs (working hours, study leave or childcare) (18)	0.342*	86	52	37	175
The role offered me more responsibility (20)	0.314*	106	44	28	178
interested in the opportunities to develop skills (5)	0.304*	147	35	7	189
service/ team used evidence based/ best practice methods (11)	0.288	54	79	40	173
There appeared to be a lot of variety in the role (19)	0.288	131	46	8	185
The organization/ team appeared dynamic and/ or had a strong vision (16)	0.278	78	66	28	172
interested in the clinical role/ nature and type of work involved in the role (7)	0.264	163	25	1	189
The resources and infrastructure available were good (23)	0.254	58	88	30	176
applying for whatever jobs were available (10)	-0.241	50	44	69	163
fitted with my childcare needs (27)	0.210	42	23	15	84
heard that the particular team was good- supportive and worked well as a team (9)	0.202*	66	59	26	151
opportunity for involvement in quality improvement (13)	0.198	66	74	29	169
service offered good career opportunities (14)	0.172	72	80	28	180
organisation had a good reputation (1)	0.166	81	79	20	180
I was interested in working in mental health (17)	0.163	176	18	0	194
I knew other people who worked here/ recommended by a friend (4)	0.159	57	41	38	136
The salary was good (8)	0.144	48	91	45	184
opportunity for involvement in research (12)	0.140	24	40	69	133
worked for the organization before and felt comfortable there (15)	0.082	49	26	31	106
Education and training programs, good professional development opportunities (3)	0.082	51	72	51	174
The location was good (22)	0.060	129	36	18	183
same location as my partner (28)	0.043	26	13	40	79
student placement here (2)	0.027	13	8	47	68
The role offered me less responsibility (21)	-0.157	14	30	106	150

Factors about why Participants were Attracted to Current Position Rating and Correlation R

Q40	Satisfaction Correlation r value	Strongly Agree (1) Agree (2)	Neutral (3), (4)	Disagree (5) Strongly Disagree (6)	Total
The work was interesting and challenging (6)	0.406*	159	31	4	194
The team had a high regard for occupational therapy (26)	0.345*	76	70	29	175
opportunity for flexibility and lifestyle needs (working hours, study leave or childcare) (18)	0.342*	86	52	37	175
The role offered me more responsibility (20)	0.314*	106	44	28	178
interested in the opportunities to develop skills (5)	0.304*	147	35	7	189
service/ team used evidence based/ best practice methods (11)	0.288	54	79	40	173
There appeared to be a lot of variety in the role (19)	0.288	131	46	8	185
The organization/ team appeared dynamic and/ or had a strong vision (16)	0.278	78	66	28	172
interested in the clinical role/ nature and type of work involved in the role (7)	0.264	163	25	1	189
The resources and infrastructure available were good (23)	0.254	58	88	30	176
fitted with my childcare needs (27)	0.210	42	23	15	84
heard that the particular team was good- supportive and worked well as a team (9)	0.202	66	59	26	151
opportunity for involvement in quality improvement (13)	0.198	66	74	29	169
service offered good career opportunities (14)	0.172	72	80	28	180
organisation had a good reputation (1)	0.166	81	79	20	180
I was interested in working in mental health (17)	0.163	176	18	0	194
I knew other people who worked here/ recommended by a friend (4)	0.159	57	41	38	136
The salary was good (8)	0.144	48	91	45	184
opportunity for involvement in research (12)	0.140	24	40	69	133
worked for the organization before and felt comfortable there (15)	0.082	49	26	31	106
Education and training programs, good professional development opportunities (3)	0.082	51	72	51	174
The location was good (22)	0.060	129	36	18	183
same location as my partner (28)	0.043	26	13	40	79
student placement here (2)	0.027	13	8	47	68
The role offered me less responsibility (21)	-0.157	14	30	106	150
applying for whatever jobs were available (10)	-0.241	50	44	69	163

Q40 The next set of questions are related to your current position, what attracted you to your current position and why you applied for it? Again there will be a series of statements for you to agree or disagree with. I was attracted to this job and applied for it… Because

	Strongly Agree (1)	Agree (2)	Somewhat Agree (3)	Total Agree	Somewhat Disagree (4)	Disagree (5)	Strongly Disagree (6)	Total disagree	Total
The organisation had a good reputation (1)	19	62	58	139	21	14	6	41	180
I had a student placement here (2)	8	5	7	20	1	31	16	48	68
The education and training programs offered were good and there were good professional development opportunities (3)	12	39	56	107	16	32	19	67	174
I knew other people who worked here/ recommended by a friend (4)	21	36	31	88	10	24	14	48	136
I was interested in the opportunities to develop skills (5)	77	70	27	174	8	3	4	15	189
The work was interesting and challenging (6)	80	79	29	188	2	3	1	6	194
I was interested in the clinical role/ nature and type of work involved in the role (7)	87	76	21	184	4	1	0	5	189
The salary was good (8)	6	42	55	103	36	27	18	81	184
I'd heard that the particular team was good- supportive and worked well as a team (9)	20	46	42	108	17	19	7	43	151
I was just applying for whatever jobs were available (10)	21	29	34	84	10	34	35	79	163
The service/ team used evidence based/ best practice methods (11)	17	37	54	108	25	32	8	65	173
There was opportunity for involvement in research (12)	4	20	17	41	23	43	26	92	133
There was opportunity for involvement in quality improvement (13)	23	43	56	122	18	16	13	47	169
I thought the service offered good career opportunities (14)	24	48	62	134	18	16	12	46	180
I'd worked for the organization before and felt comfortable there (15)	9	40	18	67	8	15	16	39	106
The organization/ team appeared dynamic and/ or had a strong vision (16)	19	59	48	126	18	17	11	46	172
I was interested in working in mental health (17)	119	57	13	189	5	0	0	5	194
The position would offer me the opportunity for flexibility and lifestyle needs (working hours, study leave or childcare) (18)	38	48	35	121	17	27	10	54	175
There appeared to be a lot of variety in the role (19)	51	80	37	168	9	6	2	17	185
The role offered me more responsibility (20)	43	63	28	134	16	21	7	44	178
The role offered me less responsibility (21)	4	10	12	26	18	56	50	124	150
The location was good (22)	56	73	28	157	8	13	5	26	183
The resources and infrastructure available were good (23)	12	46	56	114	32	18	12	62	176
The team had a high regard for occupational therapy (26)	23	53	46	122	24	15	14	53	175
The position fitted with my childcare needs (27)	20	22	19	61	4	9	6	19	84
It allowed me to work in the same location as my partner (28)	8	18	12	38	1	21	19	41	79
Other, please specify (24)	11	1	0	12	0	0	0	0	12

Q.41: Every job has its stressors and demands, we would like to hear from you what are the most stressful or demanding parts of your current job? Please select from the following list. You can chose as many or as few as you think applicable.

Stressor/ demand	n=202
Role conflict/ role blurring with other professions	75
Excessive paperwork	74
Lack of respect or understanding about OT from other professions or team	71
Multiple demands	69
Stress/ Overload	66
Chronicity of clients	62
Increasing/ Too high of a case load/ caseload size	58
Management style of team	58
Generic work/ Not using OT skills	57
Daily dealing of trauma and pain	56
Red tape and bureaucracy	55
Lack of career advancement	52
Continually having to justify OT services	43
Distance from home (commute)	*36*
Inflexible/long hours/ insufficient time for position expectation	35
Members' opinions of Occupational Therapy	19
Peer relationships	19
Lack of supervision	18
Lack of respect or understanding of the OT profession from OT team	16
Difficulty coping with job	12
Student supervision	8
Childcare issues	*7*
Fiscal/ funding/ legislation	6
Safety issues/ isolation	4
Total number of responses	976

The next question/s relate to whether you are currently considering leaving your current position.

Q. 43: I am content with my current position and wish to remain in this position.

	n= 196
Yes	144
No	52

Of the 52 respondents who answered no:

Q. 44: I often think about quitting my job.

	n=52
Yes	41
No	11

Q. 45: As soon as I can find another job, I will quit.

	n=52
Yes	32
No	20

Q. 46: I am actively looking for another job.

Answer	n= 52
Yes	43
No	9

Next, we want to hear which aspects might be most rewarding, contribute to you leaving or attracted you to a job in the future. These factors/ aspects have been compiled from previous research.

Q. 47: For the following list, please indicate what factors are the most rewarding/ positive aspects of your current position. Please select all the aspects that apply to you.

Current job- most rewarding/ positive aspects	n= 197
Direct client contact	167
Relationship with team and peers	124
Continuing education/ Professional development	103
Opportunity for professional/personal growth.	101
Work/ life balance	87
Nature of caseload	86
Program development	82
Flexibility of hours	75
Participation in service activities	72
Team opinion of occupational therapy	70
Relationship with supervisor	68
Supervision	62
Management style of team	61
Salary/ Pay	59
Holiday/ Vacation time	46
Staff supervision	41
Promotion/ career development	39
Management responsibilities	32
Caseload	32
Student supervision	19
Clinical research	10
Child care	9
Contributing positively and positive outcomes with clients and in mental health	4
Total number of responses	1449

Q66 For the following list, please indicate what factors that have helped keep you in your mental health position(s) in the past. Please select all the aspects that apply to you.

Factor	n = 147
Direct client contact/ contributing positively to client outcomes	127
Relationship with team and peers	94
Opportunity for professional growth.	81
Nature of caseload	72
Continuing education/ Professional development	72
Team opinion of occupational therapy	57
Participation in service activities	56
Management style of team	55
Program development	53
Supervision	52
Work/ life balance	50
Relationship with supervisor	48
Flexibility of hours	47
Salary/ Pay	46
Promotion/ career development	45
Management responsibilities	32
Caseload	29
Staff supervision	26
Student supervision	24
Holiday/ Vacation time/perks	24
Clinical research	11
Child care	7
Total number of responses	1108

Q. 48: For each column indicate the most important factors that are applicable to the situation described. Ranking of present with future and past factors to compare

Question: leaving/ quitting your	CURRENT job: 1	rank	in the FUTURE? 2	rank	the PAST? 3	rank
FACTOR	n= 154		n= 163		N= 127	
Stress/ Overload	65	1	84	2	47	1
Lack of career advancement	59	2	72	12	42	5
Management style of team	54	3	70	14	44	3
Promotion/ career development	53	4	66	19	22	21
Increasing/ Too high of a case load/ caseload size	49	6	77	8	29	13
Excessive paperwork	49	5	77	7	28	15
Generic work/ Not using OT skills	47	7	66	20	32	10
Multiple demands	44	9	68	18	27	18
Red tape and bureaucracy/ restructuring	44	8	79	5	36	8
Salary	42	10	70	15	27	17
Opportunities for further Education/ Additional degree/ Professional growth	41	12	81	4	21	22
Lack of respect/ team members opinions or understanding about OT- other professions	41	11	85	1	46	2
Inflexible/long hours/ insufficient time	39	14	77	9	28	16
Chronicity of clients	39	13	40	28	31	11
Role conflict/ role blurring	36	16	71	13	42	6
justify OT services	36	15	83	3	39	7
Distance from home (commute)	34	17	61	21	21	23
Daily dealing of trauma and pain	31	18	51	24	27	19
Desire to move to new geographical location	29	19	74	11	42	4
Difficulty coping with job	26	20	70	16	22	20
Peer relationships	24	22	76	10	29	14
Lack of respect or understanding of the OT profession from OT team	24	21	79	6	30	12
Lack of supervision	18	23	70	17	10	25
Relocation of spouse	17	24	54	22	17	24
Birth of child	13	26	45	26	36	9
Childcare issues	13	25	53	23	9	26
Marriage	4	28	42	27	7	27
Student supervision	4	27	48	25	4	28
Insufficient resources	1	29	1	29	0	30
Work/ life balance	1	29	0	n/a	0	n/a
Boredom	0	31	1	30	1	29
Total responses	977		1891		796	

48 (1). Factors that might contribute to you leaving/ quitting your CURRENT job:

Q 48 (1) (Factors in order of ranking)	n= 154
Stress/ Overload	65
Lack of career advancement	59
Management style of team	54
Promotion/ career development	53
Increasing/ Too high of a case load/ caseload size	49
Excessive paperwork	49
Generic work/ Not using OT skills	47
Multiple demands	44
Red tape and bureaucracy/ restructuring	44
Salary	42
Opportunities for further Education/ Additional degree/ Professional growth	41
Lack of respect/ team members opinions or understanding about OT- other professions	41
Inflexible/long hours/ insufficient time	39
Chronicity of clients	39
Role conflict/ role blurring	36
justify OT services	36
Distance from home (commute)	34
Daily dealing of trauma and pain	31
Desire to move to new geographical location	29
Difficulty coping with job	26
Peer relationships	24
Lack of respect or understanding of the OT profession from OT team	24
Lack of supervision	18
Relocation of spouse	17
Birth of child	13
Childcare issues	13
Marriage	4
Student supervision	4
Insufficient resources	1
Work/ life balance	1
Boredom	0
Total responses	977

48 (2). Factors that if they were to change, might increase the likelihood that you would want to leave in the FUTURE? In order of ranking for this particular aspect only

FACTOR	n= 163
Lack of respect/ team members opinions or understanding about OT- other professions	85
Stress/ Overload	84
justify OT services	83
Opportunities for further Education/ Additional degree/ Professional growth	81
Red tape and bureaucracy/ restructuring	79
Lack of respect or understanding of the OT profession from OT team	79
Increasing/ Too high of a case load/ caseload size	77
Excessive paperwork	77
Inflexible/long hours/ insufficient time	77
Peer relationships	76
Desire to move to new geographical location	74
Lack of career advancement	72
Role conflict/ role blurring	71
Management style of team	70
Salary	70
Difficulty coping with job	70
Lack of supervision	70
Multiple demands	68
Promotion/ career development	66
Generic work/ Not using OT skills	66
Distance from home (commute)	61
Relocation of spouse	54
Childcare issues	53
Daily dealing of trauma and pain	51
Student supervision	48
Birth of child	45
Marriage	42
Chronicity of clients	40
Insufficient resources	1
Boredom	1
Work/ life balance	0
Total responses	1891

48 (3). Factors that have prompted you to leave in the PAST?

FACTOR	n= 127
Stress/ Overload	47
Lack of respect/ team members opinions or understanding about OT- other professions	46
Management style of team	44
Lack of career advancement	42
Role conflict/ role blurring	42
Desire to move to new geographical location	42
justify OT services	39
Red tape and bureaucracy/ restructuring	36
Birth of child	36
Generic work/ Not using OT skills	32
Chronicity of clients	31
Lack of respect or understanding of the OT profession from OT team	30
Increasing/ Too high of a case load/ caseload size	29
Peer relationships	29
Excessive paperwork	28
Inflexible/long hours/ insufficient time	28
Multiple demands	27
Salary	27
Daily dealing of trauma and pain	27
Promotion/ career development	22
Difficulty coping with job	22
Opportunities for further Education/ Additional degree/ Professional growth	21
Distance from home (commute)	21
Relocation of spouse	17
Lack of supervision	10
Childcare issues	9
Marriage	7
Student supervision	4
Boredom	1
Insufficient resources	0
Work/ life balance	0
Total responses	796

Q. 49: Hypothetically, what could lure you away from your current position? Please select from the list below.

Factor:	n= 186
Higher salary	145
Promotion/ career development	122
More continuing education/ Professional development/ Further education/ additional qualifications	94
Desire to move to new geographic location/ physical location of position	92
Flexibility in hours	82
More vacation time	63
Workplaces reputation/ calibre of team/ workplace	57
Management style of team	54
Decrease/change in nature of caseload in new position	49
Decrease in paperwork	45
Relocation of spouse	44
Birth of child	42
Team opinion of occupational therapy	40
Recommendation of friend	40
More responsibility	35
Less responsibility	23
Child care	16
Increase in Supervision	16
Marriage	12
Retirement	3
New venture	3
Safe work environment	1
Total number of responses	1114

Q. 51: What occupational therapy frames of reference, frameworks or conceptual models guide your current practice? (Please select from the list below)

	n= 186	%
MOHO	128	68.9
POE	60	32.3
CMOPE	99	53.2
KAWA	26	14
Other	1	.05
Number of responses	314	

Q52 What other non-occupational therapy models or frames of reference guide your current practice? Please state:

Coding	n=136
Talk based approaches ACT, CBT, DBT, Motivational interviewing, Psychodynamic, Psychoanalytical, Psychoeducation	118
Recovery/ consumer lead recovery	50
Policies, protocols, broader health outlook (based on some general guidelines in health), team set up e.g. IDT, particular way of working/ approach of team, part of OT problem solving process or way of viewing, monitoring and evaluating treatment/ function/ progress, community outlook	39
Strengths/ humanistic	33
Cultural models e.g. Te whare tapa wha, Fonofale, Pounamu	32
Developmental, neuro based, psychological, behavioural	21
Mindfulness/ problem solving/ mentalization/groupwork- models and frameworks leading to interventions to enable people	19
Words used to describe: evidence based, best practice, client centred, TUS, Outcomes focused, Research based, own values and beliefs	17
Sensory processing/ modulation/ integration	16
Biopsychosocial, social, psychosocial	15
Boston rehab, psych rehab/ rehab model	10
Biomedical, compensatory, adaptive, rehab	10
Educational approaches, teaching/ learning, coaching, development theories	8
Supervision/ leadership/ management/ business	8
Cognitive (cognitive disabilities, Allen's) models	8
Family models	6
Total number of responses	410